

WARD TEACHING

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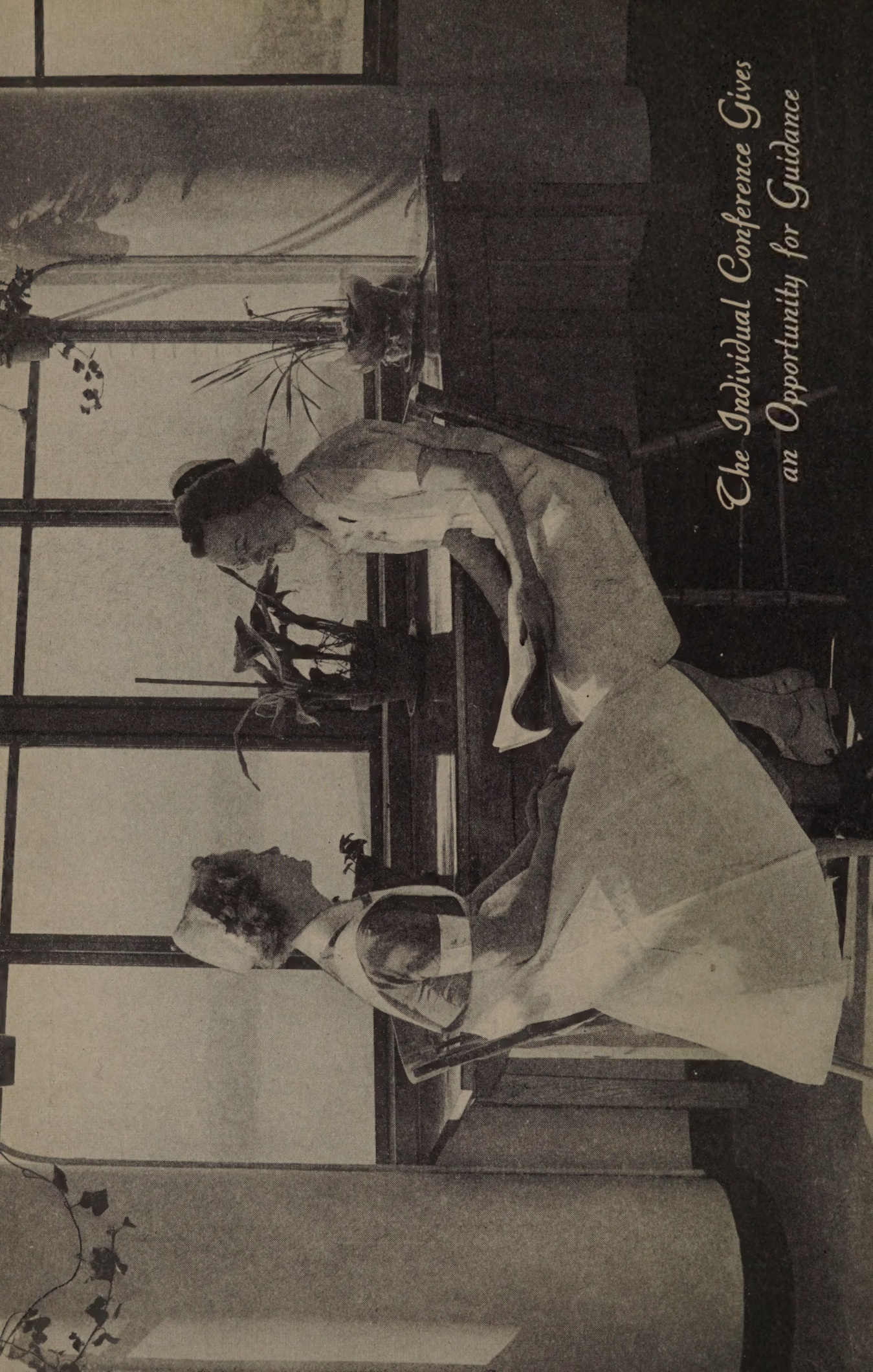
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Review of Unit 10

PROVIDENCE COLLEGE OF NURSING
390 CENTRAL AVENUE
OAKLAND, CALIFORNIA

WARD TEACHING



*The Individual Conference Gives
an Opportunity for Guidance*

WARD TEACHING

Methods of Clinical Instruction

BY

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16 Illustrations

PROVIDENCE COLLEGE OF NURSING
390 CENTRAL AVENUE
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TO
MISS SALLY JOHNSON

*who has cleared the path and
forwarded the ideals of
organized ward instruction*

Preface

THIS BOOK is written as a source of reference for the head nurse, supervisor, and ward instructor, who spend many hours daily in improving the nursing care of *the individual patient* through individual and group ward teaching. This is a tool book which the head nurse should find useful in planning and conducting her ward-teaching program, in planning ward-teaching records, and in instructing students in the care of patients. Some statements which refer to the head nurse are equally applicable to the supervisor and the reverse is likewise true.

The emphasis throughout is on methods of teaching. The problems of the beginning ward teacher are noted and the responsibilities of the more advanced teacher are considered in detail.

When a head nurse begins her function as ward instructor, she will want to familiarize herself with the concept of a ward-teaching program, her responsibilities as a ward teacher, and methods of class management. Later she will want to study and use the various methods which are described. As she more and more takes over her function, she will wish to be completely familiar with the contents of the book.

As she considers each section in detail, the suggested references will prove helpful. The starred references are particularly useful and pertinent. The other references give a broader concept both of nursing education and general education.

In presenting this book, I wish to state that it is my sincere belief that in the present day school of nursing, one of the greatest contributions which can be made to good nursing care is an organized program of ward instruction. In other words, ward instruction is basic if adequate nursing care is to be practiced.

The material is based largely on the program now in effect at the Massachusetts General Hospital. The development of the program in clinical instruction has been possible through the eager and constant efforts of the supervisors, head nurses, students, physicians, and

special workers. I deeply appreciate their assistance and vision in working through these advances.

I am greatly indebted to Miss Nellie X. Hawkinson, Professor of Nursing, University of Chicago, who has directed the development of the manuscript. I should like to express my sincere appreciation of the keen interest and valuable assistance of Miss Sally Johnson, Miss Ruth Sleeper, Miss Sallie L. Mernin, Miss Marjorie Cross, and my sister, Miss Jane Taylor, who have read and criticized the completed manuscript.

The interest and assistance of the following are very much appreciated: the faculty of the Newton Hospital School of Nursing for the material on comprehensive examinations; Miss Muriel McLatchie, Artist, and Mr. Wilbour C. Lown, Photographer, Massachusetts General Hospital, who prepared the illustrations; Mrs. Carter White, Secretary; and the Misses Alva B. Cady, Mary L. Carpenter, S. Daphne Corbett, Phoebe L. Cox, Harriet Johnson, Sarah McCullough, Harriet J. McCollum, Jennie Kornaki Smith, Lucille Theroux, Hendrika Vanderschuur, Helen C. Watters, and Marion C. Woodbury, and Mr. Harry A. Makin.

A. M. T.

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PART ONE

Fundamentals of the Ward-teaching Program

PART ONE

Fundamentals of the Ward-teaching Program

1

Description and Organization of a Ward-teaching Program

DEFINITION AND DESCRIPTION

A WARD-TEACHING program in nursing includes the individual and group instruction given to student and graduate nurses in or adjacent to the hospital ward, division, or clinic. In method, it is informal and specific. It is related closely to, but separated from, the organized clinical nursing course. The ward-teaching program is conducted most often by the supervisor or head nurse who is responsible for the division. The teaching is centered about the patient and his needs. All ward teaching should improve the nursing care of the patient. Educationally, ward teaching is the best method of teaching the student the care of the slightly ill, acutely ill, or convalescent patient for it is teaching in a life situation. The material is present in all situations; better planning will help to overcome the handicap of lack of time and the pressure of nursing service.

Every student nurse is interested in the patient and his recovery. Good teaching methods direct this natural interest toward the development of a skilled bedside nurse. The opportunity for use of progressive teaching methods is present and a better opportunity is provided than often is presented in general education. Inadequate use of method to a great degree forestalls progress. Certainly

this presents a challenge to many of us to study and improve our teaching methods.

The objectives of the ward-instruction program are:

In terms of the instructor:

1. To assist the student to give more thoughtful and intelligent nursing care.
2. To increase the interest in and ability of the student to give good nursing care through more specific interpretations.
3. To make the clinical course and experience more active and vivid, more human and personal.
4. To ensure adequate nursing care for the individual patient.
5. To develop student skill in technical procedures, and good judgment in handling nursing situations.

In terms of the student:

1. To learn how to give sound, planned, nursing care to the individual patient.
2. To learn how to observe and interpret symptoms, in the common disease conditions.
3. To master new nursing technics and develop skill in their use.
4. To develop initiative, resourcefulness, and judgment in adapting nursing procedures based on principles in the care of the individual patient.
5. To appreciate the effects of social and economic factors on the health of the patients.
6. To recognize the need for instructing the patient regarding convalescent care and health principles, and to seek an opportunity to give such instruction.

The organization of a ward-teaching program depends upon a careful analysis of and provision for certain fundamental requirements.

REQUIREMENTS OF A WARD-TEACHING PROGRAM

The essential requirements for a good ward-teaching program are:

1. A planned program based on stated objectives.
2. An evolving program based on democratic methods of planning, development, and evaluation.
3. An interested leader who recognizes and projects the importance of ward teaching.

4. An active participation by supervisors, head nurses, students, and other professional workers.
5. A good clinical experience field.
6. Ward-teaching rooms.
7. An adequate time provision for teaching.
8. A correct use of democratic teaching technics.
9. An adequate system of records.

1. **A Planned Program.** When the faculty of a school of nursing desires to improve the present ward-teaching program or to initiate a new program, a temporary chairman is appointed or a faculty member is designated by the principal of the school as the supervisor in charge of the program. She has several functions to carry out. She must determine what the status of ward teaching is, that is: the methods that are being used and how well they are being used; the general tenor or feeling of the faculty towards ward instruction; the amount of teaching which is being accomplished weekly in the various divisions; and the adequacy of the ward-instruction records.

After determining the character of the program, she should read the best current references on the subject and if possible visit one or two schools of nursing where well-established programs are in effect. On this visit, she may seek advice regarding the situations in the local hospital which present difficult problems.

Following this, the chairman presents to the principal of the school a report of the local program of ward teaching and the suggested lines of development. The report is reviewed and discussed.

The report should include or should be enlarged after conference and discussion to include definite, stated objectives of the ward-teaching program for the particular school, a brief description of the various teaching methods which are used with comments regarding improved use, information about space or rooms near or adjacent to the ward which may be used for group teaching, the average number of minutes per ward per week given to group teaching, suggested hours for scheduling ward classes, and forms used for recording procedure experience, case experience, group ward teaching, and nursing care studies. Both student and supervisory records could be included. The report really should give a clear-cut picture of the status of ward teaching in the school and serve as a starting point for a larger, evolving program.

Next, a faculty conference is called. The head nurses may be included at the discretion of the principal. The purpose of the

conference is stated several days in advance, so that the group may have opportunity to do some thinking and reading about ward-teaching programs. References may be posted. The conference should be planned to cover a two-hour period as this amount of time, at least, will be required. A classroom, library, or conference room in which a table may be set up is advised. A portable black-board is useful in presenting the objectives. The conference group should be for this period free from interruption by telephone or visitors.

The principal of the school may open the conference by stating the purpose of the meeting, and her status in relation to ward instruction. She then turns the meeting over to the chairman who presents her study of the present status of ward teaching in the school. The objectives are discussed, altered, enlarged, and finally agreed upon. Next each teaching method is presented, difficulties in its use discussed, problems related to its use in various clinical fields explained by the special supervisor for that service and a better method of use clarified. Perhaps this is as far as this first group conference may progress. The remainder of the report may be presented at a later conference. Definite recommendations and decisions as to possible steps should be made and agreed upon by the termination of the conference.

Later these first steps should be formulated in writing and distributed to the members of the conference group. The chairman may to advantage redivide these first steps into the activities to be assumed by the head nurse and activities to be assumed by the supervisor.

2. An Evolving Program. In the previous discussion a method of beginning or studying a program is presented. This general procedure might apply equally well to succeeding conferences, as it is democratic in nature. The democratic method in contrast to the autocratic method provides for free expression and participation in planning by all group members present. No one group member sits in judgment on the opinion of other members. Each should have opportunity to express her ideas and these should be considered carefully. Growth of the faculty members through active participation is the only way in which program growth may be effected.

Just as long as society is in continuous development, so two significant factors of the professional nursing school, namely, students and faculty, must have freedom for development. For these groups to progress adequately, a plan for continuous refinement of

the ward-teaching program is fundamental. Faculty conferences may be arranged for each month or more often if requested by a group member. For the conferences planned at definite intervals, the problems or topics should be stated in advance. This permits time for observation of current practice and hence first-hand information. Various problems which might be discussed at such conferences are considered in a later chapter. Usually they are administrative in nature and as they relate to varying clinical conditions, suggest tentative solutions only. This is a strength as well as a difficulty, for the changing clinical conditions in part give the program an active rather than a static nature.

3. An Interested Leader. As the program is variable as to clinical content, students, faculty, and available time for teaching, an interested leader who recognizes and projects the importance of ward teaching is fundamental. This leader should not be the nurse who is responsible for the nursing service and for getting work done; for she would be constantly divided between meeting the demands of nursing service and the needs of the school. Essentially she should be a nurse-instructor with some previous experience in formal instruction. She should be thoroughly familiar with the principles of teaching, the laws of learning, and the newer methods of informal group discussion as used in progressive education. She should know the plan and content of the curriculum of the school so that she may correlate the class and clinical program, and integrate the biological and social sciences with the advanced clinical studies.

Her major interest should be teaching. This should seem so vital to her that she is willing to practice and demonstrate technics of informal instruction. She should participate in the program by giving clinics, conferences, and demonstrations in the various divisions and by observing the teaching of head nurses and students. An excellent demonstration of a nursing clinic surpasses, in learning value, any description of the subject. Teaching by example has always been significant.

4. Active Participation. Each nurse member of the faculty who teaches students may be expected to participate in the ward-teaching program. The degree of participation will depend upon the particular functions of the nurse and her proximity to the clinical division. Although the head nurses or ward instructors carry more responsibility for the individual ward program, they should not be expected to teach the complete program. The class-

room instructors, the assistant head nurses, supervisors, staff nurses, and students may be asked to prepare and give ward-teaching periods. A tentative plan for division of responsibility may be arranged. Student and staff nurses should have supervision from the head nurse or instructor during the preparation of the material for ward teaching. As the individual nurses participate satisfactorily in the program, their interest will increase.

Physicians and special ward workers who are available may be invited to participate. The doctor may make a helpful contribution to the program by presenting individual patients who are known to the students. He may present and interpret the problems of differential diagnosis, the laboratory studies, the methods of treatment, and the significant aspects of nursing care from the medical viewpoint, which relate to one or two patients with similar conditions.

Other professional workers who may be available and willing to participate are the social worker, the dietitian, the occupational therapist, the physical therapist, and the public health nurse. As these groups are working to improve the condition of the patient, they are able in many instances to make helpful contributions regarding special aspects of care, and convalescent and future needs.

5. Good Clinical Experience Field. This implies that the divisions or wards to which students are assigned will have a daily average number of patients sufficient to supply a good quantity and quality of experience. Any suggested number would be arbitrary for it would be altered by the length of stay of the patients and the number of students sharing in the experience field.

Physical equipment should be available so that nursing care may be planned and technics carried out effectively. The equipment should be kept in good condition. Provision should be made for general cleaning or housekeeping. All nurses ought to be held responsible for the condition and after care of the equipment which they use in giving bedside care, and in most instances are held responsible for the bedside unit or patient's room. Maintaining a satisfactory environment for the patient is a nursing responsibility. Unless this is given considerable attention, good health and hygiene principles cannot be taught effectively.

Provision for graduate nursing service is considered an additional essential in most practice fields. This person may be an assistant head nurse or staff nurse. She may be sent to the division only when needed, or again she may be assigned as a full-time worker.

She affords the head nurse a little more freedom in planning assignments. For example, if first year students are assigned to the floor, the staff nurse may care for the critically ill patients, while if third year students who need special clinical case experience are assigned, the staff nurse may care for the patients who are convalescing or who have uncomplicated conditions.

A segregated clinical service facilitates the general plan of teaching on the different floors as it allows for division of responsibility for teaching relative to major disease conditions and permits some specialization, particularly in the highly specialized clinical fields. Better integration of subject matter in regard to the needs and care of the average patient is the advantage of a non-segregated service. Here the patient is the center of attention rather than a highly specialized condition or research. In both experience fields, ward teaching needs to be done.

6. Ward-teaching Rooms. The group ward teaching should take place in a treatment room, classroom, or other available space near the ward where a patient may be conveyed with comparative ease. The room designated as the teaching room should admit as many students as there are in the group. It should contain chairs, a blackboard, wire or molding for displaying charts, and a study table or desk.

To convert a treatment room into a part-time teaching room, a blackboard may be hung, and a bookcase (made by the hospital carpenter shop) may be placed on an end wall. This in no way hampers the usual use of the room.

Other rooms which may be used for teaching include the sun porch, the visitors' room, an unused linen room, the internes' laboratory, the admitting room, or the patients' smoking room. In other words, any room where students may sit comfortably and see, and where a patient or equipment may be brought, will provide a room for ward teaching. In one hospital in which linen trucks were introduced, the linen rooms have been given to the school as teaching rooms. The shelves in part have been retained for books and teaching material. Camp stools have been stored easily under the lower book shelf. The walls were painted a light, attractive color.

In another institution, a portable blackboard was purchased for use in teaching in the patients' smoking room. This is stored in a hall closet between ward classes.

Provision should be made for seating the group. Camp stools can be secured in most situations. They are inexpensive and re-

placements are infrequent. They are particularly advantageous if a treatment room is used, as straight chairs may overcrowd a small room with its collection of necessary equipment. Collapsible chairs are recommended if funds are available.

When group teaching takes place at the bedside, the group remains standing. Less often should it occur at the head nurse's desk or within hearing distance of the patient as this inhibits discussion and divides attention.

Although in some schools teaching rooms may be considered almost an impossibility, in others they have been obtained and considered valuable. If only the end of a corridor can be partitioned off, a place is provided where the student can read and interpret the medical record, plan the patient's nursing care, write the nursing care study, or have a conference with the head nurse without interruption. Some place needs to be provided where ward teaching and learning can be accomplished.

7. Time. A desirable time for planned group teaching is two and one-half hours or 150 minutes each week. This includes planned group conferences, clinics, demonstrations, and excludes uniform inspection, fire drills, and housekeeping routine. This might be given in five half-hour periods or three half-hour periods and three twenty-minute periods. These may be held immediately after the morning report, i.e., 7:10 to 7:40; from 7:40 to 8:10 (this allows the night nurse time for breakfast before the teaching period); from 8:00 to 8:30. Teaching is possible between 7:10 and 7:40 when the patients' breakfasts are served by a dietitian and kitchen maid and trays are carried by a ward helper. A staff nurse left in the ward at this time can give general oversight and essential nursing care. The time at which the teaching is scheduled is determined somewhat by the presence of an 8:00 o'clock class, by the doctors' rounds, and perhaps by the hour at which the student leaves the ward for the out-patient clinic assignment. The teaching need not be done at the same hour each day; i.e., a head nurse or supervisor may teach at 7:10 or 7:15, a doctor may teach at 8:00 or 3:30, and a dietitian may teach at 8:30. Again, the ward schedule may permit a class from 10 to 10:30, 11 to 11:30, or between 1:00 and 2:00.

Each ward or division should achieve not less than two hours of planned group teaching per week. Any amount below this should be cause for concern. The desirable standard would be two and one-half hours. No standard number of hours has been arrived at

MASSACHUSETTS GENERAL HOSPITAL
TRAINING SCHOOL FOR NURSES

Ward B-1

WARD TEACHING SCHEDULE

Week of May 13, 1940

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Topic	Nursing care of Cushing's Syndrome Patient A. Patient B. Patient V.	Normal diet modification for patients with Cushing's Syndrome	Cushing's Syndrome Patient A. Patient B. Patient V.	Care of acutely ill and dying patients	Quiz on Cushing's Syndrome	Fire drill. Discussion of patients
Lecturer	Miss K.	Miss W.	Dr. P.	Miss C.	Miss K.	Miss C.
Time	7:40 A. M.	7:40 A.M.	7:40 A.M.	7:40 A.M.	7:40 A.M.	7:40 A.M.
Place	Ether Dome	Staff room	Staff room	Staff room	Staff room	Staff room
Topic	(Head nurse)	(Dietitian)		(Supervisor)	(Head nurse)	(Supervisor)
Lecturer						
Time						
Place						

FIG. 1. Form for Ward Teaching Schedule.

for weekly or total experience in a clinical specialty. With the frequency of evening duty with its accompanying absence from group teaching, a student should be expected to maintain an average of two hours per week. In one school, the student on evening duty is required to attend ward classes held in the morning; these are placed on the daily time slip as are other classes. The time, however, is made up to her. In one university hospital, the ward classes for advanced students are given twice, that is, repeated, to permit all students to attend. Usually one class is held in the morning and one in the early afternoon.

The following times are suggested as minimum ward-teaching hours for each student in the various clinical specialties:

	Weeks	Hours
Medical	16-24	32-48
Surgical	16-24	32-48
Pediatric	12-16	24-32
Obstetric	12-16	24-32

In the special services with increased initial instruction in procedures and care, two and one-half hours per week are suggested.

	Weeks	Hours
Orthopedic	4- 6	10-15
Urologic	4- 6	10-15
Dermatologic	4- 6	10-15
Psychiatric and Neurologic	8-16	20-40

The total ward-teaching time per student would be from 162 to 245 hours for the clinical services. This is exclusive of the Diet Kitchen, the Operating Room, and the Out-patient Clinics.

8. Democratic Teaching Technics. A correct use of democratic teaching technics is fundamental to a satisfactory ward program. Part Two of this book is devoted to a presentation of these methods.

The methods and practices of ward instruction in common use include:

A. Group conference

Relative to Morning and Evening Report

Regarding nursing care and needs of a particular patient

Relative to morning rounds

Orientation conference for new nurses

Census: 23.

MASSACHUSETTS GENERAL HOSPITAL

Daily Ward Report

Ward: B-1

Date: 5/10/40

Male: #

E.S.

E.M.

N.M.

C.M.

Skin

Psy.

Female:

W.S.

W.M. #

N.S.

Orth.

Urol.

Admissicns			Discharges								
Transfers			Ward Teaching								
			Topic: Discussion of Nursing Problems. Patients W., Z., I.								
			Instructor: Miss T. Time: 30 minutes								
Transfers			Topic:								
			Instructor:								
			Time:								
<div>Boarders</div> <table> <tr> <th>Name</th> <th>From</th> <th>On</th> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>			Name	From	On				Surgical Preparations		
Name	From	On									
Supervisor's Notes											

FIG. 2A. Daily Ward Report Form.

B. Individual conference

Head nurse—Supervisor

Student—Head nurse

Student—Supervisor

C. Nursing Clinic—given by doctor, head nurse, supervisor, social worker, dietitian, occupational therapist, physical therapist**D. Nursing demonstration**—given by head nurse, supervisor, and others**E. Nursing care plan****F. Nursing care study****G. Daily patient assignment****H. Evaluation of student progress and ward program**

9. Adequate System of Records. Records are of two kinds, those which pertain to the general program and those which are kept by the student. The weekly ward-teaching schedule is essential in all programs. As the hospital stay of the average patient is of short duration, weekly planning of teaching seems advisable. This usually takes place in a conference of the supervisor or nurse in charge of the program and the head nurse. When several wards are planning the teaching together, the supervisor should meet with the head nurses representing a clinical specialty. Following the conference, the schedule (page 11) is made out in duplicate, one copy being sent to the nursing school office and the other retained in the ward. These may be posted in the nursing school office and corrected by the head nurses as alterations in the week's program occur. The schedule is convenient for reference of the supervisor or instructor who wishes to visit the teaching on various wards. This practice is helpful and should be encouraged.

If difficulty is experienced in knowing how much group ward teaching is given from day to day, the following suggestion may be useful. On the late afternoon report sheet, a space may be provided for recording daily ward teaching as to topic, instructor, and time. (See page 13.) The supervisor who makes late afternoon rounds to visit the newly admitted and acutely ill patients posts the ward-teaching time in minutes on the office schedules and makes any corrections regarding the topic or instructor. She may do this just before seven o'clock while waiting to give the day report to the night supervisor, or at whatever hour the change in nursing service occurs. This is a satisfactory method of knowing how much instruction is given from day to day.

At the end of the week the total teaching time may be tabulated

for each ward. If the amount is below standard, the head nurse may be notified. One poster board or bulletin board will carry schedules of all wards for six months, furnishing a good running record of the total time and selection of ward-teaching topics.

Student Record of Ward Teaching. The student should keep a record of her planned instruction and experience in the various clinical services. This record should be cumulative and in such a form that each supervisor or head nurse may know the scope of the ward instruction which previously has been given. The record may to advantage include sheets for recording procedure experience, group ward teaching, patient experience, and nursing care studies.

At the Massachusetts General Hospital, each student records her ward teaching in a book referred to as the "Ward Instruction Record." This includes various procedure sheets for the general and special services, lists of conditions which are considered basic to the student's experience, various sheets for recording group ward teaching for the general and special services, and the nursing care study record.

The purposes of the "Ward Instruction Record" are stated as follows:

- A. To secure a well-rounded program and an accurate record of clinical instruction.
- B. To ensure adequate practice in the nursing procedures for the various services.
- C. To provide for the essential experience in caring for patients with the more common disease conditions.
- D. To aid the head nurse in the assignment of patients and to guide the head nurse and supervisor in planning the weekly schedule of ward instruction.

The Record is issued to each student at the beginning of the third term of the first year. The Nursing Procedure Records A and B (see Section D, page 286), have been initialed by the Instructor in Nursing Arts. The student begins at once to master the procedures listed on A, to record experience in caring for patients with major disease conditions, and to check her attendance at ward classes. Sample forms for recording experience and ward classes may be found in Section C, page 285, and Section B, page 283.

Students coming to the school for affiliation use the Record in the same manner as the students enrolled in the School of Nursing.

MASSACHUSETTS GENERAL HOSPITAL

SCHOOL OF NURSING

WARD INSTRUCTION RECORD
SUMMARY SHEET

Note: Class hour - 50 minutes

STUDENT:		ENTERED SCHOOL:		GRADUATED:		
Clinical Service	Ward	Total Hours	Year Given			Remarks
Medical			1	2	3	
Surgical						
Mixed						
Urologic						
Neuro-Psychiatric						
Orthopedic						
Skin						
Pediatric						
Out-Patient						
Additional Instruction						

TOTAL HOURS:

FIG. 3. Summary Sheet for Ward Instruction.

NURSING CARE STUDIES

Service	Date	Ward	Grade	Diagnosis
Medical				
Surgical				
Urologic				
Neuro-Psychiatric				
Orthopedic				
Skin				
Pediatric				
Out-Patient				
Operating Room				
Other Studies				

Date record completed _____

Supervisor _____

FIG. 4. Summary Sheet for Nursing Care Studies.

A summary sheet of ward instruction (pages 17 and 18) is made out for each student after graduation. This gives the total hours of teaching received in each clinical specialty and a list of the nursing care studies. This becomes part of the student's permanent record.

In tabulating the ward-instruction hours for the summary sheet, it is essential to follow the custom of the formal class schedule in regard to the use of clock hours or fifty minute periods. If the classroom hour is considered to be fifty minutes in length, consistency should be observed by dividing the total number of teaching minutes by fifty rather than sixty. Such a procedure must be determined by the individual school.

The person or department responsible for permanent class records may be assigned the responsibility for the ward-instruction summary sheets. Several schools consider it desirable to place the total hours of ward instruction on the student's permanent class record.

This chapter has been devoted to a presentation of the essential requirements of a ward-teaching program. There are many problems which arise as the program grows and becomes more exacting. These problems and various technics for improving the program are discussed in Chapter Four.

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2

Orientation to Ward Teaching

PRELIMINARY CONFERENCE

WHEN a head nurse assumes responsibility for a ward to which student nurses are assigned, she acknowledges that she has a definite teaching function and works toward making herself increasingly able to perform this function. Before she takes charge of the ward, the nurse in charge of the ward-instruction program should meet with her. The purpose of this conference is to acquaint the head nurse with:

1. The plan of ward instruction for the clinical service and ward.
2. The succession of units or content of the program.
3. The relationship of the ward teaching to the clinical nursing courses and to other courses of study which are correlated with the clinical nursing courses.
4. The clinical course outline, or outlines, if the service is non-segregated, and reference lists.
5. The age and previous experience of students in the school.
6. The forms for recording ward teaching.

Following this conference, the head nurse may be expected to observe ward teaching and begin to make out written plans for informal instruction.

PRELIMINARY OBSERVATION OF WARD TEACHING

Before the head nurse assumes responsibility for the ward teaching, she should arrange her time that she may observe the teaching occurring on her future ward or a similar ward. She should give attention to the general procedures in conducting a ward-teaching group. She need not try to grasp the situation as a whole but may on different days concentrate on different details, such as:

1. The physical condition of the room used for ward teaching; the preparation which the head nurse has made for the group.
2. The relationship between the head nurse and students.
3. The manner in which the head nurse brings the group to attention and presents the material.
4. The methods the head nurse uses to hold attention, and the devices used to interest inattentive students.
5. The provision for student participation throughout the period.
6. The method of relating each day's topic with the preceding one.
7. The specific teaching technics such as questioning, use of illustrative material, use of textbooks, and references.
8. Method of and time for making the assignment.

FUNCTIONS ON ASSUMING RESPONSIBILITY

The head nurse, on assuming responsibility, should as soon as possible:

1. Take inventory of the reference books, issues of the American Journal of Nursing, and other teaching materials which are available on the ward.
2. Read any material on the ward relative to ward teaching and administration.
3. Obtain file box with 3×5 cards on which to list the name and year in the school of each student assigned to the ward. These cards may be used as the beginning of anecdotal records. If only two or three students are assigned to the ward, this would be unnecessary.
4. Obtain file box with 5×8 cards to use for recording teaching plans.
5. Begin a bibliography for the clinical specialty. This is kept on 3×5 cards in a small indexed file box.
6. Determine when her first teaching period is to occur and begin to prepare for it.
7. Review the cumulative records of ward instruction of the students assigned to the ward. Note that one is on hand for each student and return any incomplete or old records of students not on the ward to the nursing office.
8. Make note of those patients who show the need of special nursing care, supportive care, instruction, and need for consultation with special workers.

MANAGEMENT OF WARD CLASS

The head nurse who is able to manage a ward-teaching period without wasting time and energy possesses one characteristic essential for teaching. The room used for group teaching, the illustrative materials, the head nurse-instructor, and the students are the factors to be controlled.

The head nurse manages the group by careful planning and by thorough execution of plans. If she is systematic and orderly in her procedure, she will have little difficulty in managing the group. The maxim, "know what you are going to do, what the students are going to do, and how it is to be done," will prove an invaluable aid if properly and consistently carried out.

"Good management implies the avoidance of distractions and the creation of a harmonious class atmosphere, through the control of the personal factors in the relationships of the teacher and students. The ordinary student respects the teacher's command of the subject matter as evidenced by [her] display of genuine enthusiasm and by [her] ability to enrich the classwork from [her] own fund of knowledge and experience. Similarly she responds to the teacher's manner of address. She is inattentive to passive, colorless, inarticulate language, but is receptive to pleasant, clearly enunciated, well-modulated speech. She is also impressed favorably or unfavorably by all personal factors such as dress, posture, mannerisms, and attitudes. The extent to which the . . . teacher can develop a personal interest in and a sympathetic attitude toward each student in the class and can without affectation convey that attitude to her, to that extent will [she] establish a basis for mutual respect and cooperation." *

Suggestions for Managing the Ward Class

1. Physical Condition of the Room Used for Ward Teaching. Have the room prepared by a monitor 15 minutes before the teaching period. This includes correct ventilation and arrangement for lighting, provision for sufficient seats for the number of students who are to attend, and arrangement of any needed demonstration or work table. The monitor also will keep the bulletin board and blackboard clean and orderly, and the teaching room attractive and in readiness for work.

* The Department of Home Economics—A Handbook. University High School Journal. Volume XI, Number 4, March, 1932, page 326. Published by the University of California.

2. Seating. Have the students take seats as soon as they enter the room. If possible, have students take alternate or widely separated seats for tests and quizzes.

3. Controlling Attention. Prepare all reference and demonstration material in advance of the teaching period and have it available at the proper time. Begin the teaching immediately at the time planned. Do not permit delay to occur. The time of instructors is precious. If, however, you anticipate a few minutes' delay, provide something for the students to do. Introduce the topic with an interesting or challenging relevant question or statement. Visualize the responses of students to your questions and plan the successive details accordingly. Create immediately in your students a desire and need for the day's subject. Plan for as much student activity and response as possible, and plan to challenge every student in the various levels of experience.

Allow no one to remain long out of attention. Plan only for such material as can be completed in the period provided. Plan short, spirited, purposeful discussions. Use a variety of illustrative material and vary your teaching methods. Illustrate all possible steps in the material with objective devices. This is particularly significant if new material is being presented. Reward intelligent participation with sincere praise and commendation.

4. Quizzes. Give quizzes at the beginning of the hour only. If they are to be corrected in class, make certain that the answers are objective and that the directions for checking are clear.

Students may check, but rarely do they grade one another's papers. Ask the monitor to distribute the papers. Do not expect each student to leave her seat to get her paper or to reach over the heads of those in front in an ungainly fashion. Be prompt and consistent in correcting and returning written work whenever it is advantageous to the majority of the group.

5. Recording Ward Teaching. Be specific regarding the method of recording the ward teaching at the close of the hour. State the subject or heading—according to the current record system, the name of the instructor, the time, and the type of teaching to be recorded.

6. Student Response. Allow for individual response rather than group oral expression. Ask for a show of hands in answer to a question, then after sufficient time has been given for formulating a reply, call on one or more students for comparative answers. Show

fairness in the distribution of student response. If possible, bring each student into the discussion.

Do not tolerate private conversations. If talking or confusion occurs, pause temporarily. Do not try to talk it down or raise your voice above the murmur.

7. Disciplinary Problems. The following are suggestive only. Such problems should be discussed with the supervisor or nurse in charge of the ward-teaching program. A student may be requested to take a particular seat at future periods. Call the attention of the student to the fact that he or she is disturbing the group. She may be requested later to summarize the subject matter for the class in which her observation appeared inattentive; this summary should be discussed with the student. Assign some definite activity to the student in several succeeding teaching periods, such as getting out equipment or arranging a demonstration.

Discipline may be maintained by establishing wholesome relationships with students. "Liking grows out of mutual respect. Respect develops from the cultivation of the right kind of personal relationships. In establishing right relationships with students, the teacher will:

1. Be personally attentive to the class as it assembles; stand before the students in an accustomed place; greet them quietly, pleasantly, and if possible personally.

2. Be consistent and systematic in beginning each day's work. Insist upon complete attention at the beginning of the recitation.

3. Be purposeful, sympathetic, fair-minded, courteous, and firm in all relations with students; in general appearance, dress, poise, voice, and the use of English, exhibit force and command respect; direct attention ultimately away from self to interest in the subject.

4. Relieve tense situations with humor, avoid sarcasm, and overcome anger with charity.

5. Attempt to understand each student; give every student opportunity to express himself frequently; hold the forward student in check and encourage the retiring one; maintain a personal interest in each but an impersonal attitude toward his conduct.

6. Watch for evidences of inattention and misbehavior, and discover and remove the causes; appeal to the personal pride of individual leaders and to the social pride of the group; place on students the responsibility for reflecting on the results of their social conduct, for setting up desirable standards, and for living up to them.

7. If individuals develop into disciplinary problems deal with them personally and obtain the help of the supervising teacher if necessary.

8. Never hesitate to commend a good act in the presence of a student." *

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* The Department of Home Economics—A Handbook. University High School Journal. Volume XI, Number 4, March, 1932, page 330. Published by the University of California.

3

The Written Plan for Informal Instruction

DEFINITION

THE WRITTEN plan is the name used for the outline of the activities and subject matter which the head nurse or supervisor proposes to include in the period which she spends with the ward-teaching group. Also, it is an outline of the achievements to be accomplished and the technics by which these are realized.

In ward teaching, the more formal, time-honored lesson plan is infrequently used. However, the *daily plan for informal instruction* is of real significance. In the use of the discussion method, by careful planning time may be saved and the purpose of the teaching accomplished. The form of the plan varies with the purpose. Although the type may change, effective planning will be an essential in good teaching. The head nurse should obtain adequate knowledge of the subject matter, of her students, of the psychology of learning, and of teaching methods, in order to plan most advantageously.

Subject matter is a means through which the teacher expects to effect growth in student nurses and improve the nursing care of the patients. She should be thoroughly familiar with subject matter. She obtains this knowledge by careful survey of the available references, by conferences with the supervisor or doctor if the subject is in the field of research, and by interpretations of clinical observations. If the Index Medicus, which is found often in the medical library of the hospital, does not contain references to the topic under study, the doctor may have good reference material in his office file.

By referring to the students' previous records of case experience

and ward instruction, by conference with the supervisor, and by questions asked by students, the head nurse may determine the background of knowledge in a subject-matter field. This is essential in making a satisfactory teaching plan for a new group of students.

PRINCIPLES OF EFFECTIVE LEARNING

The head nurse needs to know the relationship between the laws of learning and the ward-teaching situation. A list of sound educational principles may be found in any book on principles of teaching. A simple list of the principles of effective learning to consider in ward teaching is as follows: *

- "1. First impressions are apt to be lasting.
2. Strong motives tend to stimulate (or retard) the learning process.
3. Too rapid an introduction to professional responsibilities may present so many new problems that motivation and initiative tend to be weakened.
4. When learning is accompanied by satisfaction, it is likely to be more effective than when it is accompanied by dissatisfaction.
5. Every application serves to fix learning.
6. The more intense and vivid the stimulation, the greater the opportunity for economical learning."

Through a knowledge of psychological principles governing learning, the head nurse should be better able to:

1. Motivate her daily teaching.
2. Organize the teaching around the needs and interests of the students and anticipate student reactions.
3. Choose and use the most effective technics in helping students to learn.
4. Anticipate the amount of subject matter which the student can grasp in a ward-teaching period.
5. Evaluate the results of her teaching.

In other words, daily outlines should be planned on the basis of this knowledge.

Method is determined through a consideration of the subject matter to be presented and the previous experiences of the students in the clinical specialty. A clear differentiation of method is basic and

* From Wayland, M. M.: *The Hospital Head Nurse*, 1938, pp. 217-222. By permission of The Macmillan Company, publishers.

repetition in the use of any one method should be avoided. For a description of various ward-teaching methods, refer to Part Two. The head nurse should study her approach in presenting new material, for an unfortunate teaching method may be the inhibiting factor in learning. A student nurse sent to give a colostomy enema without provision for a previous learning period of observation and discussion is inhibited and conditioned toward this abnormality which she hopes to make a normality in the eyes of the patient. The head nurse must know how students learn, she must keep the subject matter simple, concrete, and related to the individual patient and his needs.

The advantages of the *written plan* are that it provides for:

1. A consideration of the objectives of the individual teaching period and good sequence of the new with the previous teaching.
2. A selection of subject matter adapted to the needs of the students.
3. A decision as to the best method of teaching.
4. A plan for continuity and the avoidance of repetition.
5. The selection of illustrative materials, activities, and pivotal questions.
6. Certain aspects of testing and evaluation.

The values of the *daily lesson plan*, according to Bossing, are: *

- "1. Lesson planning insures a definite objective of the lesson.
2. It insures a proper connection of the new with the previous lesson.
3. It insures some scheme of selection and organization of subject matter, materials, and activities.
4. It directs the teacher's attention to the type of teaching procedure most desirable.
5. It provides for adequate summaries of the lesson.
6. It provides for an adequate checking of the outcome of instruction.
7. It stimulates the teacher to provide pivotal questions and illustrations.
8. It insures some unity in lesson development.
9. It insures a definite assignment.
10. It makes possible adequate adaptation to individual differences in pupils.

* Bossing, N. L.: *Progressive Methods of Teaching in Secondary Schools*, Boston, Houghton Mifflin, 1935, pp. 205-210.

11. It tends to insure availability of materials for lesson use when needed.

12. It creates assurance on the part of the teacher, and greater freedom of teaching."

The written plan is superior to the unwritten plan in the following respects:

1. The written plan provides for a definiteness in writing. Clarity of thinking results from a written description.

2. The written plan evokes more logical thinking and better planning in terms of the teaching unit.

3. It is a protection against forgetting, hence a time-saver.

4. It provides freedom in teaching and a means of retracing in case of digression of thought.

5. It provides an opportunity for continuous improvement of content and related activities.

The essential parts of the written plan for the ward-teaching period are:

1. The ward situation out of which teaching arises.

2. The aim which is definitely stated.

3. The subject matter adequate for the time allotment.

4. The illustrations, visual or oral.

5. The methods of motivation and teaching.

6. The assignment.

7. The summary.

8. The evaluation technics.

The form of the plan varies with the subject matter, the head nurse's best practice, and the purpose of the lesson. The two-column plan which is taught in teachers' colleges is helpful to the beginning teacher in differentiating between content and method. It also provides for a variety of method and affords opportunity for good variation in questioning. In the two-column arrangement, the left-hand side of the page is given to an outline of subject matter and the right to method, questioning, and indications for use of illustrative materials. The value of this plan lies in the training in organization of subject matter. It is well for the beginning teacher to use this method for several months. An example of the two-column plan occurs on page 31. As she becomes more adept in teaching methods, she may use the outline form to advantage. An example of the simple outline plan for group ward teaching is given on page 36.

Suggestions Relative to the Progressive Improvement of Written Plans. The plan is intended as a guide to the head nurse in her daily ward teaching. It is intended to stimulate thought and may be modified or supplemented as the situation requires. It is only the starting point and must be constantly developed and revised. The plan is a tool which even the most expert ward instructors must use in effective teaching. No group-teaching period should be conducted without it for the degree of planning controls, to a great extent, the subsequent learning of the students.

As one's ability in teaching increases, one may feel confident to progress towards less detailed plans. This is a matter for individual consideration. Some teachers of long experience prefer to use detailed teaching outlines.

Many instructors, in preparation for teaching, write out a detailed outline—a study outline in fact, which never is brought to the classroom. After the teaching has been planned with the greatest of care, a brief guide is copied and used in class. This ensures an excellent background of related information and a freedom from notes for class use. If difficulty is experienced in conducting an active discussion group, this technic may prove helpful.

If the discussion leads away from the plan, it is not always essential to return to the original outline. The decision depends upon the purpose of the teaching period, the plan for further development of this unit of subject matter on successive days, and the relative importance of the major and the newly developed issues. If the unexpected outcomes can be anticipated, the head nurse may wish to continue the discussion in the diverted direction.

A fast-moving, intensive discussion period about the present and imminent needs of a particular patient provides the most stimulating type of teaching for both the young and the advanced head nurse. But it can only progress with ease when the problem has been analyzed and the discussion procedure well-planned. Often the outline is not obvious and is revealed quite subtly as the lesson progresses. This is an interesting form of instruction for students.

The head nurse may bring to class a folder of supplementary information, such as illustrations, additional references on aspects of the subject which may be considered, and reprints or tear sheets of major articles. (Tear sheets are simple pages which have been removed, usually from periodicals, for quick reference and ease in filing.) Teaching aids serve as a back log which may be used to answer a question, or to enlarge upon a point in which further dis-

cussion is indicated. The head nurse should have many more illustrations than she intends to use as students respond to different visual aids. Majority comprehension is essential at each major step in the discussion.

Use of Cards. As the clinical knowledge is constantly changing, it is suggested that cards be used for lesson outlines. Ruled cards 5×8 inches in size allow adequate space for a good outline. Material may be crossed out, additional cards added, and the material remolded to fit the pertinent needs of the class, or one for which there is not time to plan. Particularly in the hospital, where acutely ill patients presenting urgent teaching problems arrive overnight, and the head nurse feels the need for immediate instructions, cards at hand with outlines of up-to-the-minute information are extremely helpful.

If the daily group conference, clinic, and demonstration material is presented from cards, within a few months a rich content of clinical material will be built up such as is available in few text or reference books or periodicals.

EXAMPLE OF THE TWO-COLUMN PLAN

I. *Pediatric Ward Problem Out of Which Teaching Arises:*

Last week a boy of 10 years of age was admitted with a provisional diagnosis of intracranial tumor. As these patients are infrequent on this particular service in this hospital, the case has been the topic of interest for the three (30 minute) morning teaching periods of the past week. This summary is to be used by the head nurse on Saturday morning. Time—20 minutes.

II. *Head Nurse's Aim:*

1. To review the outstanding facts concerning a postoperative brain tumor, various aspects of which have been the subject of discussion during the past week.

2. To anticipate and suggest, with class aid, the essential problems arising from this case, with a possible solution.

III. *Topical Outline of Lesson:*

1. The points upon which a doctor may make a diagnosis of brain tumor.

2. Points in nursing care which must be emphasized.

3. Instruction to family at time the patient leaves the hospital.

SUBJECT MATTER

METHOD

I. *Points upon which a doctor may make a diagnosis of brain tumor.*

Evidence of intracranial pressure.

Symptoms which indicate the location of it.

Evidences of intracranial pressure.

1. Bulging of optic discs.
2. Spreading of sutures:
(Shown by x-ray only.)
3. Cracked pot resonance upon tapping cranium.
4. Shadow-like fingerprints, indicating pressure of convolutions against cranial wall. (By x-ray.)
5. Diplopia.
6. Headaches and projectile vomiting not associated with gastro-intestinal disturbances.

Symptoms which indicate location of tumor.

1. Staggering gait and lack of co-ordination indicate cerebellar pressure.
2. Strabismus indicates pressure on sixth nerve, inhibiting it so that stimuli to the external rectus cause the weakened eye to turn in.

What are the two points upon which a doctor may make a diagnosis of brain tumor?

What evidence would indicate intracranial pressure?

Which of these did Willie show?
diplopia

projectile vomiting upon arising

What other symptoms did the child show?

crossing of the eyes
jerky gait

What do these symptoms indicate?

Comment: All these symptoms are recognizable by the nurse except the bulging of the optic disc.

What is the value to the nurse of a knowledge of diagnostic points?

(Early diagnosis imperative for treatment.)

SUBJECT MATTER

METHOD

II. *Points in nursing care which must be emphasized.*

What are the nursing measures used in prevention of shock?

A. Patient suffered considerable shock, so all principles of shock should be applied.

1. Bed warm.
2. Child warm.
3. Child quiet.

B. Frequent turning of child, as often as every half hour. Patient is uncomfortable with no pain.

Characterize the discomfort which this patient is experiencing.

Describe the care which may enable this patient to rest.

1. Prevent pressure from cast. (General pain.)
2. Prevent pressure sores.
3. Changing position rests patient.
4. Prevent sterile meningitis. Subject to meningitis from absorption of blood clots. *Sign*: Rise in temperature.

What is the cause of sterile meningitis?

C. Keep absolutely quiet, *except to*:

1. Interrupt rest for position change.
2. Interrupt rest for nourishment.
3. Give periodic surgical care.
4. Speaking causes marked nervousness.

SUBJECT MATTER

METHOD

III. *Instruction to family at time patient leaves hospital.*

A. Make child happy for prognosis is unfavorable. Two graduate nurses are to be at home constantly. They will provide nursing care when needed for this child.

B. Child needs a happy, quiet, wholesome life.

1. Provision for physical care of child.

2. Study during daytime versus evening study.

3. Mental quiet and relaxation versus excitement.

4. Need for mild recreation versus boisterous play.

C. The operation is a delicate one upon brain tissue, necessitating great care and inactivity for some time.

D. Refer the family to the physician for any information regarding the prognosis.

E. Consult with the head nurse before advising the parents in any situation as critical as the present one.

What is the chief problem in this home concerning which the nurse will advise?

What reason would you give to show the importance of this condition not only for the child's happiness but for the parents' peace of mind later on?

What would you answer if one of the nurses in the family asked you directly about the prognosis?

Whose approval would you seek for any advice you were about to give the family?

EXAMPLE OF THE OUTLINE PLAN

I. *Surgical ward situation out of which teaching arises:*

Two days ago, John Peters, a laborer of 35 years of age, was admitted for a reduction of hernia. This is one condition in which the postoperative care and instruction are similar in almost all cases. Miss T., the head nurse on the men's surgical division, who has prepared this outline for a previous period, uses it in planning her teaching to first-year students. She will adapt it in presenting the care which Mr. Peters will need. Time—30 minutes.

II. *Head Nurse's aim:*

- A. To present the customary medical and nursing care for a patient with hernia.

III. *Topical outline of lesson:*

- A. Pre-operative care.
- B. Postoperative care.
- C. Discharge instructions.

IV. *Outline of content:*

- A. Pre-operative care.
 - 1. Teach patient to void flat in bed.
 - a. Method of obtaining urinal.
 - b. Need of ensuring privacy.
 - 2. Bi-daily surgical preparation.
 - a. When Galli Repair, the thigh on the opposite side from the hernia is prepared.
 - b. Spinal—depends on anesthesia.
 - 3. Cleansing enema, preferably at bedtime. Otherwise in early morning.
 - 4. Bedtime medication.
 - 5. Mental preparation as for other patients.
- B. Postoperative care:
 - Chief consideration:* All strain on abdominal muscles must be eliminated in order to prevent recurrence.
 - 1. Anesthesia.
 - a. Spinal—avoids vomiting.
 - b. Local—narcotic given upon return from operating room.
 - 2. Position—flat in bed with one pillow under head and one under knees. Patient's knees and chest on same level for 14 days or until permitted to sit up in chair.

- a. Explain desired position to patient.
- b. On fifth day, with absorption of sutures, warn patient against over-exertion and give more help with morning care.
- c. Aid patient in eating; later teach patient to feed himself. As soon as patient is able to take fluids, teach him to do so without lifting his head.
3. Change position every two hours to prevent pulmonary congestion and hypostatic pneumonia. Assist patient in turning and bolster with pillow in front, at back, and between flexed knees.
 - a. Balkan frame—to facilitate changing of position. Teach patient to use shoulder muscles.
 - b. Report coughing immediately.
Cough syrup given freely, as ordered.
Inhalations.
4. Binders—while in bed.
 - a. Scultetus.
 - b. Bender bandages.
5. Scrotal support—used when hernia descends into scrotum. Trauma during operation causes edema or hemorrhage which is demonstrated by swelling.
 - a. Types used:
Alexander binder—adjustable.
Suspensories, mesh, three sizes.
Bellevue bridge—six-inch adhesive strips strapped across the thighs.
6. Ice cap every two hours for comfort and to aid in absorption of fluids.
7. Note staining of dressings, character of drainage.
8. Note voiding—because of operative site, shock, trauma of bladder, and retention are common.
 - a. Patient not to strain or to sit up in bed to void.
 - b. Try all suggestive means of inducing micturition.
Warm drink.
Blow water in glass.
Warm urinal.
Oil of peppermint.
 - c. Catheterize after 10 to 12 hours. If longer, place bed on low shock blocks.
9. Fluids—to 2000 cc. to maintain fluid balance and aid voiding.

10. Medication—routine as in abdominal surgery—to prevent pain but principally to decrease restlessness and tossing in bed.
11. Bowel hygiene—no bowel movement until third day, post-operatively, when a cleansing enema and mineral oil are ordered to prevent distention and constipation. Rectal tube used only with doctor's order.

C. Discharge instructions:

1. Abdominal support only if patient is obese and has general relaxation of abdominal muscles.
2. Scrotal support until check-up examination in clinic or by local family doctor. Four to six weeks.
3. Bowel hygiene—mineral oil to regulate and lubricate, to avoid constipation, i.e., straining and distention.
4. Diet—as desired.
5. No active, strenuous exercise. No lifting, no straining, no heavy pushing. After three weeks, climb stairs if necessary, one step at a time, stopping on every step. May drive car in six weeks. Return to work is variable; no manual labor for six months.

THE UNIT PLAN

The daily plans for group teaching in one ward over a period of 4 to 10 days may center about the presentation of a unit of subject matter. This may be regarding several patients with similar medical conditions and nursing situations which provide an excellent center for discussion.

Definition. Burton defines a unit as * “a significant and comprehensive aspect of the environment.” The unit plan is an outline for teaching the subject matter in a limited field of activity. It gives sequence to the daily content.

The essential elements of the unit according to Yoakam and Simpson are:†

- “1. The statement of the problem or subject.
2. The aims of the unit.

* Burton, W. H.: *The Nature and Direction of Learning*, New York, Appleton, 1929, p. 574.

† From Yoakam, G. A., and R. G. Simpson: *An Introduction to Teaching and Learning*, 1934, p. 77. By permission of The Macmillan Company, publishers.

3. Reference material (selected).
4. Introduction (if needed).
5. Outline of procedure (including suggestive problems, suggestions for study, etc.).
6. Directions for the preparation of papers, talks, etc.
7. Assimilation test by which the student checks his progress."

Daily Teaching as Part of the Unit Plan. Each day's plan is a segment or a progressive part of the whole or unit plan. Both the daily plan and the unit must show thoughtful arrangement. The plan should be flexible and adapted to the needs of the students and subject matter to be presented. The unit may be the plan for teaching the total needs of the cardiac patient in its many varying aspects or it may refer to the teaching relative to the care of one or several patients following a craniotomy. A series of such units may make up the group ward-teaching outline for a particular division or clinical service. Several head nurses and supervisors may be involved in the making of the plan or, if highly specialized, it may represent the thinking of one head nurse and apply to one division only.

The unit plan for the clinical service, if so constructed, may take the form of a mimeographed study guide or learning outline which is distributed to each student. This has been used with a certain degree of success in the operating room where the subject matter is technical. A study guide serves as a plan for teaching as well as a plan for learning. One objection to a set guide is that in some instances it may permit the instructor to stop planning and thinking about teaching and hence to an extent curb her future growth. Guides are helpful when used correctly as they systematize teaching. Frequent revision is necessary.

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4

Administration of the Ward-teaching Program

ATTITUDE OF THE FACULTY

A MAJOR consideration in the satisfactory administration of the ward-instruction program is the attitude of the faculty. A positive attitude should begin with the director or principal of the school and permeate through the entire nursing staff. The purpose of the program in terms of the faculty is to improve the nursing care of the individual patient and to provide for the growth and nursing skill of the individual student. It is essential to plan for a more correct and broader understanding of these purposes as staff changes occur and faculty members develop.

The problems of administration are considered under two large headings:

A. Providing for growth of the faculty and program through in-service education.

B. Maintaining a program of good quality.

PROVIDING FOR GROWTH OF FACULTY AND PROGRAM

An in-service program to interpret the aims is basic to the maintenance of the ward-instruction program. In-service education may be planned on two levels, the first for head nurses and assistant head nurses, and the second for instructors and supervisors. The particular arrangement is dependent upon the educational resources of the community, the educational and professional background of the staff and the size of the faculty. The in-service program should be an

evolving one. Also it should be based on the expressed needs of the staff.

Many good programs may be arranged. The following are suggested:

Program A—Methods of Ward Instruction:

1. Lesson planning
2. Group conference
 - Surgical ward
 - Medical ward
3. Morning report, evening report
4. Nursing clinic
 - Pediatric ward
 - Medical ward
5. Orientation of student to ward
6. Individual conference regarding nursing care
7. Individual conference regarding efficiency report
8. Nursing demonstration
 - Surgical nursing procedure
 - Obstetric nursing procedure
9. Nursing care plan
10. Nursing care study
 - Medical service
 - Surgical service
 - Operating room service
 - Pediatric service
 - Psychiatric service
 - Obstetric service
 - Dietary service
11. Daily assignment of patients

Program B—Analysis of Clinical Experience:

1. Purpose and method of study of clinical experience
 - Disease conditions
 - Procedures and treatments
2. Technics of analyzing incidence of disease conditions, occurrence of procedures
3. Value and use of this analysis in the assignment of patients
4. Reports of analyses in the various clinical specialties
5. Selective assignment of patients
6. Providing for procedure experience of various wards

7. Recording clinical experience
8. Specialization of head nurses in various nursing procedures

Other programs may be planned on teaching aids, evaluation of student achievement, comprehensive examinations in a clinical specialty, evaluation of head-nurse achievement including the construction of a head-nurse rating scale, study of individualized nursing care, instruction of patient in health principles and convalescent needs.

The program must provide for individual conferences and guidance. There are two reasons for this. First, the in-service program as such gives general direction and projects new ideas. It may recouch old practices into educational method. Rarely does it provide for review of familiar material. Hence as individuals learn at varying rates of speed and need to make varying applications of the general principles, guidance through individual conference is essential. Secondly, as most head nurses are not on an academic appointment basis, they enter and leave the faculty group at varying points in the program. An orientation conference on entering the program is extremely helpful.

Individual guidance helps the head nurse to see the importance of ward teaching in the development of students. The supervisor may point out to the head nurse the increased interest of the students in Mr. Peters, who has a peptic ulcer, through the presentation of the patient as an individual. How much more interesting the patient becomes. This develops insight into the patient's needs for complete recovery and disappearance of the ulcer. Certainly students grow in social understanding. Again the supervisor may suggest that on successive mornings the head nurse may give the student direction and supervision in the plan for morning care for several patients. If guidance is afforded, at the end of a week, the head nurse should observe more thoughtful planning and hence, some small degree of student growth.

Again, the head nurse will need guidance and direction in carrying out various teaching methods. Their use varies as to clinical service and according to the interests of the head nurse. The supervisor may observe which methods the head nurse uses best and which she uses less well. She may suggest that she visit the teaching of the head nurse who uses expertly, the method in which she is less skilled.

The supervisor may suggest the need of a series of demonstration classes in methods of teaching whenever her group of head nurses

seems to become careless in the use of methods or as new members are added to the group. She will attempt of course, first to care for her own difficulties through individual or small group conferences.

A plan should exist which provides for faculty conferences to correct errors, proceed with the planned program and provide for progress. The larger conference group may need occasionally to break down into a smaller group consisting of the supervisors or ward instructors to discuss certain aspects of the program which are not of direct interest to the total group.

The program should be interpreted to the administrative supervisors. They should be given some part in it, for participation increases interest and support.

MAINTAINING A PROGRAM OF GOOD QUALITY

There are many problems in maintaining a program of good quality. Several are suggested and considered in detail. They vary in significance and in difficulty with each school of nursing.

Planning the Daily Teaching. The weekly planning should be a joint activity of several head nurses and their supervisor or instructor. The head nurses on a group of wards of one service, for example, medical, meet together with the ward supervisor to plan the teaching for the coming week. These small group conferences are referred to as *Unit Conferences*. The term unit is used as the conference group consists of the supervisors and head nurses in one or two related clinical specialties. They are held for the express purpose of planning the ward teaching for the coming week. A good day is Tuesday, which allows sufficient time to arrange for special lecturers or group leaders.

The head nurses should bring the list of diagnoses of their patients, the list of students, and the weekly time and assignment sheets. Both the head nurses and the supervisor suggest teaching topics. The aim should be toward co-operative planning.

Occasionally two wards of the same service which are close together may combine for their teaching. This is indicated particularly for clinics given by social workers or dietitians, as it is difficult to make heavy demands on the time of workers in other hospital departments. Combining two wards may release one head nurse to observe teaching in another division, hence enlarging her concept of teaching technic.

On the surgical wards, if several doctors are available for teach-

ing, they may rotate in giving clinics; each interne on the teaching list might give a clinic every two weeks. The head nurse suggests the topic under discussion that week, and the interne with the co-operation of the head nurse selects the patient. It should be understood that when doctors' clinics have been omitted they are to be rescheduled usually within the course of the week.

Whenever possible, special instructors add richness and variety to the teaching program. The special instructors who might be used are the social worker and the dietitian regularly assigned to the ward or service, the occupational therapist, the physical therapist, and the public health nurse. During the past year, the following schedule for special lecturers has been set up for the majority of the wards of one hospital. Arrangement was made for one special instructor each week.

First week (or third), public health nurse

Second week, social worker

Third week (or first), supervisor of clinical instruction

Fourth week, dietitian

In the medical wards, the occupational therapist had a tentative appointment for the first Thursday of each month.

The weekly ward schedule was planned in the following manner. On the basis of five teaching periods per week, the distribution to be observed was:

One clinic by a doctor

One special instructor as indicated above

One period by the supervisor

One period by the head nurse

One period by the student—intermediate or senior.

If six teaching periods were planned, the additional period was given by the head nurse, assistant head nurse, or staff nurse.

Essentially the plan of scheduling must vary for the individual school. However, the supervisor should guard against any head nurse giving more than two weekly periods of teaching. Frequently the young head nurse considers it easier to do the teaching than to instruct others in teaching methods. The supervisor should prepare and give several teaching periods each week for essentially she is a teacher and may demonstrate good teaching by actual participation. Daily she should attend the ward-instruction periods of her various wards.

In the school in which a ward-teaching program is being initiated, it may be possible to give only one or two periods per week. A smaller amount of good instruction is preferable to no instruction or to a greater quantity of lesser quality. Each period of twenty, thirty, or forty-five minutes makes its contribution to the learning of student nurses. The wise supervisor knows what she would like to aim towards but because of the pressure of nursing service, her aim frequently is deferred. She sets her standard number of hours per week at an obtainable level. During those weeks when she is able to increase the amount of teaching, she makes every effort to do so.

The plan of the ward teaching and the arrangement and length of the ward classes will vary with the clinical service. A certain degree of variation is essential and may be anticipated. Factors which provoke variation are the length of time the student has been in the school, her previous clinical experience, her class schedule, early morning classes and rounds, the doctors' clinics, the operative schedule, and the teaching demands of the service.

In initiating the ward-teaching schedule, the nurse who plans the formal class schedules must be consulted. She will be able to indicate the days on which she plans to schedule 8:00 or 9:00 o'clock classes throughout the year. It may be possible to co-ordinate the two schedules, namely the ward teaching and the formal classroom schedules, to the advantage of the ward instruction. In the past the full-time classroom instructors have had comparative freedom in the scheduling of classes. With the advent of planned ward classes, this freedom will be increasingly curtailed. Hence co-operation and interpretation are of extreme importance.

Selecting the Teaching Content. The center of the ward-teaching program is the patient. As a general rule, the weekly sequence of topics follows that of the more formal clinical course for the related clinical service. This is simplified by supplying each head nurse with a date, hour, and topic schedule for the course. These are furnished by the nurse in charge of the class program. If this course is not in progress, or if patients with related disease conditions are not available, the head nurse should plan to study patients with significant nursing problems or conditions with similar teaching situations.

The weekly schedule should lend itself to change when an acutely-ill patient is admitted, presenting a good teaching opportunity. Situations on the ward that demonstrate an immediate teaching need

should have precedence over those of a less urgent nature. A felt need such as instruction regarding the use of the oxygen tent for an acutely-ill pneumonia patient or the care of Southey's tubes for a cardiac patient with gross dependent edema would be typical indications for a change in the teaching schedule.

The head nurse representing a clinical service should work toward assembling a list of suggested topics for group and individual teaching. These should be particularly common to the division and clinical service. Again the supervisor may plan a list of activities or material which the head nurse in a certain division is completely responsible for teaching.

The topics should not duplicate those already included in a more formal course of study. Repetitions of factual material should be avoided. The topics might enlarge upon conditions which have been presented in a general way. Several kinds of lists or outlines may be set up. The following are suggested:

1. Brief outline for a specialized service.
2. Detailed topic outline arranged according to units or systems affected.
3. Detailed list of topics arranged in alphabetical order.

The brief outline (page 54) usually includes a list of major conditions about which teaching is to be done, procedures which may be demonstrated at the bedside or in the treatment room, and specific patient teaching which is essential experience. The outline, however brief, should be in the sequence of the more formal clinical course.

The detailed topic outline, arranged according to units or systems affected, may be an enlargement of the brief outline. A suggested outline for medical ward instruction is given on page 56. It should not be adopted for use in any school without adjustments which consider local needs. Such a list gives breadth and richness to the program.

A detailed list of topics arranged alphabetically may serve as the only type of outline in a limited specialty or may serve as a second work or topic list in a larger clinical area. In many schools, this list might be too long to be useful except as a check list of topics regarding which teaching should be done. Lists of topics such as occur in the student's "Ward Instruction Record" in use at the Massachusetts General Hospital may be found in Appendix A.

The correct method of determining the content of the ward-teach-

ing program is on the basis of a ward-experience analysis.* The head nurses, under the direction of their respective supervisors, may keep a detailed daily record of case experience over a period of from twelve to eighteen months. If this is impossible because of lack of time, a sampling of typical months showing seasonal changes may be made several times per year. From this list the head nurses and supervisors may determine which wards offer the most abundant experience in the various major disease conditions. It may be decided in a group conference which head nurses will emphasize certain aspects of surgical care, of medical care, etc. On one men's surgical ward, hernia, colostomy, burns, and minor surgery may be emphasized, while on a women's surgical ward thyroidectomy, carcinoma of the reproductive system, hemorrhoids, and cholecystectomy are emphasized. With such a division, the teaching is more definitely in relation to the available experience and the head nurse tends to become a specialist in several aspects of surgical nursing care.

Once a list is set up, little deviation should be made. This tends to ensure a uniform clinical content between the ward instruction of several students in the various seasons and the elimination of duplication in the various services. A uniform clinical content is dependent also on the mode of assignment to the ward and clinical service.

Maintaining Programs of Similar Quality in All Clinical Services to Which Students Are Assigned. When ward-teaching programs of the same level or quality are maintained in all wards to which students are assigned, the program assumes more importance. If it is carried out only in part or is poorly done, it loses importance in the minds of the students.

Maintaining a uniformly good program is one of the major functions of the supervisor of clinical instruction or the nurse responsible for the ward-teaching program. This may be accomplished in part through conferences, through setting up a suggested outline of teaching and by a list of supervisory and head-nurse functions.

Providing Time for Ward Instruction. In many hospitals it may be possible to reorganize the ward routine in such a manner as to provide time for teaching under normal conditions. On analysis of the hourly functions of the head nurse, it may be found that between 7:30 and 10:00 in the morning she is at her desk preparing orders for the following day, planning student time or preparing discharge records. During this time she should be either conducting

* Several forms for analysis are available. Rottman and Pfefferkorn: *Clinical Education in Nursing*, Macmillan, 1932, pp. 10-25, 71-74.

morning teaching or supervising bedside care. It is the most important time for the head nurse to be at the bedside of the patient.

It may be possible for two wards to combine in conducting the program. In this case, each head nurse might attend the group teaching for three mornings and on alternate mornings assume charge of both wards.

Carrying out the program when the wards are shortest and busiest and the clinical material is good is a difficult problem. If staff nurses are employed, it may be possible to have a "float" or "relief nurse" assigned to the ward to give additional nursing service and release students for teaching. A supervisor may assign the float in her own building with regard to ward-teaching needs. If part of the teaching must be omitted, it should be understood that this is a temporary omission only. The program should be resumed as soon as possible. A head nurse should not be given the privilege of omitting the planned teaching without first consulting the school office. Better planning of the daily time schedule often provides for the needed minutes. If the supervisor will keep running notes of the important teaching situations which were missed because of the pressure of nursing service, sufficient data may be collected to show the need of more staff nurses.

Maintaining a System of Student Ward-teaching Records Simple Enough to be Carried Out. The number of records should be kept at a minimum and the type should be uncomplicated and readily usable. Specific directions relative to the use of records are essential. The administration of the records presents several problems, such as keeping the records up-to-date, avoiding duplication in checking by both the head nurse and supervisor, and setting time limits for completion of records on the various services.

A specific discussion of these problems in connection with the "Ward Instruction Record" may be suggestive. The details which to the reader may seem unnecessary, at present, are essential for administering the program in a satisfactory manner.

1. Getting the students to record ward teaching and experience. The students bring their Records to the teaching period. They record the teaching at the end of the period before leaving the classroom. The head nurse or supervisor in charge of the period announces the time and place for recording. At this time also, the students record the basic conditions in which they have had experience since the last meeting. The nurse in charge of the period is

responsible for seeing that all who attend morning teaching sign on the back of the schedule.

2. *Division of responsibility for checking Records.* The head nurse has full responsibility for the checking of procedure sheets. The supervisor has full responsibility for the checking of ward instruction sheets. If an assistant head nurse is assigned to the ward, the head nurse has full responsibility for the checking of the basic conditions lists, with the aid of the assistant head nurse; if there is no assistant head nurse, the supervisor alternates with the head nurse in checking the basic conditions lists.

3. *Plan and devices for checking.* On the ward-teaching schedule, the head nurse designates the day on which she plans to set aside a period for checking the Records. At this time, she delegates another nurse to be in charge, goes to the teaching room, and closes the door. (She is not expected to check the Records at her desk nor to take them home at night.) The head nurse checks as many Records as possible with the students, who meanwhile are recording their procedure practice.

On the basic conditions list, the head nurse places a small red mark on the right vertical block line following the student's last recording. This denotes where it stood at the head nurse's last checking and whether the student is receiving and recording experience in the major disease conditions.

In the private pavilion with non-segregated services, a sheet is placed inside the cover on which the student lists her patients and diagnoses. This facilitates checking the records on a ward with non-segregated services.

4. *Getting the instruction tools on the ward.* A new student coming to the ward brings with her the class program card which assists the head nurse with assignments and classes, "Ward Instruction Record," and manila folder for teaching notes. Unless some immediate responsibility which affects the condition of the patient forbids it, the student who fails to bring these tools with her is sent to obtain them.

5. *Ensuring that the Records are complete when the student leaves the service.* Except for those changes which occur as an emergency or on Monday, the student will have her Record complete 24 hours in advance of leaving the ward and will leave a note in the place specified by the supervisor that her Record is ready and that she is leaving the ward. If the change is an emergency or on Monday,

the student will leave a note for the supervisor, telling where she has gone and that the Record will be ready in 24 hours.

The student should feel that the Record is her responsibility and that "Co-operation" on the Ward Report refers also to the ward-instruction program.

Delegating Responsibilities. The setting up and delegating of responsibilities of the supervisors, head nurses, and students, relative to ward teaching is important in maintaining a good program. The functions of these three groups will vary with the faculty organization and size of the school of nursing. However, functions should be clearly stated. The following lists may be suggestive:

I. Responsibilities of the supervisor:

A. Group teaching

1. Conduct the weekly conference at which the teaching is planned for the coming week. Plan out the division of teaching to be given by the head nurse, supervisor, student, interne, or social worker. Contact special lecturers.

Maintain an average of two and one-half hours in each ward per week.

2. Leave the schedules for the coming week in the school office by Saturday. Keep the office schedules up-to-date.

Total the hours of teaching for the previous week on the office schedules by Monday noon.

3. Give three periods of teaching per week. Attend teaching daily when not giving a ward class.

Review the head-nurses' teaching plans occasionally before they are presented. Write observation reports on the teaching of the head nurses. Assist the head nurses in reviewing the conferences and clinics which the students are to present.

Attend morning and evening report on the wards once weekly.

B. Individual teaching

1. Observe use of case assignment method. Assist student in caring for the acutely-ill patients and in giving convalescent instructions. Suggest references to students regarding their patients. Observe insight into health and social aspects. Observe work of students in need of special help at least once weekly. Discuss observations with the student.
2. Plan out a method of recording nursing-care studies assigned, received, and completed. Assist the head nurse in assign-

ment and evaluation of nursing-care studies. Read all of the completed studies. Assist head nurse in conducting conferences with students while studies are being written.

3. Keep an inclusive bibliography in the clinical specialty. Begin a file of illustrative materials and useful pamphlets. Add to this material. Use 5 × 8 cards for written teaching plans.

II. *Responsibilities of the head nurse:*

1. Maintain a good standard of ward instruction. Approach the morning and evening reports as learning situations. Present well-prepared conferences, clinics, and demonstrations. Topics should be narrowed down with a small area fully covered. Keep the ward-teaching group small in size. Tend toward an increased number of bedside clinics and demonstrations; vary the methods used. Conduct conferences with students regarding the group teaching they are to present. This is one way in which the teaching can be made of value to all who attend. Make it possible for students to read case records. Post changes in the teaching schedule in the school office. Call the school office before omitting any teaching.
2. Observe and report difficulties with the case-assignment method. If patients are changed on Monday, students may have an opportunity on Sunday to read the case records. Help the student to see the patients' problems and ways of solving them. Suggest references to further the understanding of the patient and his condition. Keep progress notes on nursing care given by students. Discuss the anecdotes weekly with the supervisor.
3. Assist student in selecting a patient for a nursing-care study. Study should offer a challenge to student. Learn whether a newly-assigned student will be required to write a study. Conduct a conference with student while the study is being written. When completed, read and estimate a grade. Give it to supervisor within a week from the day it is received.
4. Keep an inclusive bibliography. Use the supervisor's bibliography file for additional references. Add to the illustrative material for use in the clinical service.
5. Keep a list of questions patients ask concerning disease, health, hygiene, and convalescence, as a basis for a more specific health-education program.

6. Begin and keep a loose-leaf notebook of administrative regulations and aids to head nursing.

III. *Responsibilities of the student:*

1. Arrive at the teaching period on time with a fountain pen, notebook, and ward-teaching record. Sign name on the attendance slip before leaving the teaching period.
2. If special duty includes the preparation of the teaching room, see that sufficient chairs are available, chalk is at hand, and the room is well ventilated. Assist the instructor in placing or holding charts used as illustrative material. Make sure that the patient is ready for clinic, if he is to be shown.
3. When notified or posted to conduct a teaching period, consult with the head nurse at her earliest convenience concerning the scope of the content, the references, and the length of the period. The lesson plan should be completed and ready for conference at least 24 hours before the date of the period. No student teaching is to be given without a final conference on the prepared material either with the head nurse or the supervisor. When presenting the lesson plan to the head nurse, the appointment for the conference should be made. Be sufficiently familiar with the material so that there will be no need to read the content verbatim from the cards. Invite questions and group discussion. Make sure that teaching begins and ends on time.
4. Participate actively in the ward teaching. If pertinent questions are unanswered, pursue them further. Consult the head nurse, doctor, or supervisor after conference. Suggest to the head nurse topics of major interest for discussion in the ward teaching, such as problems in teaching patients, problems in nursing care, or patients' problems.
5. On the first day of assignment to a new ward, bring notebook, class program, and ward-teaching records. Give these to the head nurse when reporting for duty.
6. When assigned to a new ward or division make it a responsibility to know whether a nursing-care study is to be written. If so, decide which patient presents the best learning situation in terms of nursing problems and the degree of previous experience in the school. Consult the head nurse concerning selection. A diagnosis already pursued in a study

should not be duplicated. After the study is underway, consult the head nurse and supervisor regarding the value of a conference. Unless special arrangement is made, all studies are due two weeks after the selection of the patient is agreed upon.

7. Read the case record whenever the name of the patient is posted for clinic or conference on the ward-teaching schedule. Be sufficiently familiar with the social and causative aspects to discuss the teaching need and opportunities which the patient presents. If additional assignments are posted on the ward bulletin board the student makes it her responsibility to read them.
8. Make use of the bibliography card file in the ward to prepare teaching material or a nursing-care study. Use the reference books in the ward and reference library to explain statements in the case records.
9. When scheduled to leave a service, have ward-teaching records complete and ready to be checked. In the place specified by the supervisor, leave a note stating the day of leaving and that records are complete. If the change is an emergency or occurs on Monday, leave a note for the supervisor, stating the name of the new ward and the date on which the records will be completed.
10. Keep ward-teaching records up-to-date by recording procedure practice weekly and ward instruction and case experience daily. On the ward-teaching schedule, the head nurse designates the day on which she plans to review records. Have records complete on this day. It is only through keeping an accurate, up-to-date set of records that the head nurse can know what gaps exist in the student's clinical experience. It is only on the basis of the current record that a more adequate program can be planned.

A BRIEF TEACHING OUTLINE FOR AN ORTHOPEDIC WARD *

DATE: First week

UNIT: Orthopedic conditions of the hip

* To this ward the student is assigned for an uninterrupted service of four weeks. The selection of subjects is made with reference to the patients available for conference and clinic.

CHOICE OF SUBJECT:

1. Tuberculosis
2. Arthritis
3. Congenital dislocation of the hip
4. Slipped femoral epiphysis
5. Legg's disease
6. Fractures
7. Intra-pelvic protrusion

DEMONSTRATION:

1. Care of the patient in traction
2. Bradford frame for hips
3. Care of patient in a plaster spica cast

DATE: Second week

UNIT: Orthopedic conditions of the knee

CHOICE OF SUBJECT:

1. Tuberculosis
2. Arthritis
3. Internal derangement of the knee
 - a. Displaced cartilage
 - b. Osteochondritis dissecans
4. Slipping patella

DEMONSTRATION:

1. Measuring for and teaching use of crutches

DATE: Third week

UNIT: Orthopedic conditions of the ankle and foot

CHOICE OF SUBJECT:

1. Club feet
2. Hallux valgus
3. Deformities of foot and ankle due to poliomyelitis
4. Congenital anomalies
5. Hammer toes
6. Pronated feet

DEMONSTRATION:

1. Proper placing of feet for walking
2. Exercises for developing the muscles of the feet
3. Method of applying lower extremity brace
4. Methods of strapping feet and making plaster impressions for foot plates

DATE: Fourth week

UNIT: Orthopedic conditions of the back

CHOICE OF SUBJECT:

1. Pott's disease
2. Congenital anomalies
3. Arthritis
4. Sacro-iliac conditions
5. Spondylolisthesis
6. Scoliosis

DEMONSTRATION:

1. Care of plaster shells
2. Application of back brace
3. Application of sacro-iliac belt
4. Postural exercises
5. Use of Bradford frames for immobilization of the spine

DATE: Fifth week

UNIT: Miscellaneous orthopedic conditions

CHOICE OF SUBJECT:

1. Torticollis
2. Spastic paralysis
3. Osgood-Schlatter's disease
4. Bursitis of shoulder
5. Dislocations of shoulder

DEMONSTRATION:

1. Traction and supports for torticollis
2. Instruction for nursing care of bursitis of shoulder
3. Care of patient in shoulder spica

A DETAILED TEACHING OUTLINE FOR A MEDICAL WARD *

Each medical condition is presented from the standpoint of the individual patient in the ward who is suffering from the condition. The major emphasis is on the nursing and convalescent needs. Methods of treatment and laboratory tests should be presented in relation to a particular patient.

* This detailed teaching outline is a revision of an article by the writer which occurs in the American Journal of Nursing for November, 1938.

UNIT I: *Nursing in Conditions of the Respiratory System:*

1. Pneumonia

Types of lobar pneumonia.

Incidence in relation to the types. Serums available for use in each type. Program of State Department of Public Health, in relation to availability of serum.

Demonstration of preparation and adjustment of oxygen tent in pneumonia.

Methods of giving oxygen; types of tents used in the hospital; methods of testing the concentration of oxygen in the tent air; the testing solution; use of ice to reduce air temperature; mechanics of operating the tent and of changing tanks.

Care of patient with this condition in the oxygen tent.

Methods of obtaining rest for the patient; the problems involved in each instance.

Medications in lobar pneumonia. Chemotherapy, toxic effects, therapeutic use and special observation and nursing care related to chemotherapy.

Laboratory tests in diagnosis and treatment.

Diet and fluids. Indicate preferences and needs.

Provision for adequate convalescence.

Incidence of broncho-pneumonia in relation to lobar pneumonia.

A contrast of the two conditions as to onset, symptoms, incidence, age groups, course, and complications.

2. Tuberculosis

Care of tuberculous patient in the hospital.

Related treatments of surgical nature, as pneumothorax, pneumolysis.

Care of tuberculous patient in the home. Reference to the social situation of a patient who has been discharged.

Advantages of sanatorium care and local methods of placement.

Health aspects and prevention of tuberculosis. Statistics on incidence in the city and state.

Precautions used in preventing the spread of pulmonary tuberculosis. Emphasis on covering the mouth when coughing and careful collection and handling of sputum; care of dishes.

Health teaching of hospital patient recently diagnosed as having pulmonary tuberculosis. Procedure for follow-up of contacts.

Appreciation of patient's emotional reaction to his diagnosis.

3. Other conditions

Care of patient with bronchiectasis.

Method of securing postural drainage in bronchiectasis.

Use of cold vaccines.

Care of patient with asthma.

Method of treatment in asthma, including the use of aqueous and peanut-oil preparations of adrenalin. Use of helium gas.

Demonstration of sprays and inhalers.

Lipiodol injections: preparation of patient and assistance with treatment.

Diet in relation to asthma.

Clinical picture and care of patient with serum sickness.

Demonstration of throat irrigation in care of patient with pharyngeal edema.

UNIT II: *Nursing in Conditions of the Circulatory System, Blood, and Blood-forming Organs*

Care of cardiac patient. Comfortable positions. Demonstration of arrangement of pillows, foot-board, and other comfort measures.

Supportive and specific medication used in cardiac disease.

Individual responses to digitalization as observed in patients.

Water balance for the cardiac patient. Average fluid intake, need and importance of accurate measuring and recording of intake and output. The reason and instances in which fluids are restricted. Instruction of patient in method of measuring fluids.

Prevention of decubitus ulcer.

Methods of feeding the cardiac patient; the diet, its limitations, and the need for considering preferences.

Health teaching of patient with hypertension, with coronary thrombosis.

Use of oxygen tent for the cardiac patient; the open and closed B.L.B. mask.

Special treatments for the relief of distressing symptoms—paracentesis, thoracentesis, phlebotomy, intravenous glucose. Nursing responsibilities.

Occupational and diversional therapies for the patient with rheumatic heart disease, subacute bacterial endocarditis.

Occupational limitations in coronary heart disease. Problems

- involved in securing positions. Suitable occupations. Attitude of industry toward a cardiac cripple.
- Explanation of physiology and treatment of acute pulmonary edema, of gross dependent edema. Demonstration of use of Southey's drainage tubes, the problems involved.
- Care of adolescent with rheumatic fever. Explanation of function of rest as a method of treatment.
- Use of medication in rheumatic fever; response of patient.
- Function of social worker in planning for long-time convalescence in rheumatic fever.
- Problems of adjustment and attitudes in chronic illness.
- Use of hematinics in relation to the blood count; response to this treatment.
- Administration of liver extract in variable doses in incipient and advanced primary anemia. Intramuscular injections.
- Care of patient with primary anemia with central nervous system complications.
- Consideration of psychologic aspect of anemia.
- Care of patient with hemophilia. Nursing considerations in the prevention of bleeding. Some agents used as coagulants.
- Occupational and diversional therapy for the hemophiliac patient.

UNIT III: *Nursing in Conditions of the Urinary Tract*

- Care of patient with nephritis; apprehension in nephritis.
- Salyrgan in nephritis in relation to the urinary output. Other medications used in nephritis. Mandelic acid regimen.
- Dietary treatment in nephritis.
- Laboratory tests used in nephritis. Changes anticipated from the normal blood chemistry.
- Care of patient with malignant hypertension, with uremia.

UNIT IV: *Nursing in Conditions of the Gastro-intestinal System*

1. Peptic ulcer

- Care of patient in gross hematemesis associated with a bleeding gastric ulcer.
- Care of patient suffering from a chronic peptic ulcer, helping the patient accept bed rest.
- Medications used in peptic ulcer, status of alkaline powders.
- Frequent danger signs in peptic ulcer; their significance.
- Dietary treatment of peptic ulcer, problems and progress of

patient. New trends in feeding gastric patients, Meulengracht diet.

Dietary instruction of patient at discharge.

Observation of gastroscopy. Preparation and after care of patient, discomforts.

Health instruction of patient with chronic peptic ulcer.

Psychic factors associated with gastric disturbances. Function of social worker in helping patient to solve his social problems. Ways in which nurse co-operates with other workers.

Supportive care of patient with carcinoma of stomach.

Diagnostic tests: gastric analysis, gastro-intestinal x-ray series, barium enema; preparation and after care of patient, his reaction; value in making diagnosis.

2. Typhoid fever

Care of patient with typhoid fever.

Medical aseptic technic used in typhoid fever nursing: particular points to observe, methods of establishing isolation routine and of setting up the unit in a single room or ward.

Medical and dietary treatment of typhoid fever. Danger signs to be observed and complications to be avoided.

Typhoid fever as a public health problem. Epidemiology, decreasing incidence, and prevention.

3. Other conditions

Care of patient with taenia saginata. Nursing in relation to the medical treatment.

Demonstration of the equipment required and the nurse's responsibility in assisting with a proctoscopy. Care of biopsy specimen or culture.

Care of patient with cholecystitis.

Care of patient with cirrhosis of liver, special care with bleeding esophageal varices. Contrast differences in two patients, considering other complications.

Care of patient with acute yellow atrophy.

Medical and dietary treatment of constipation in bed patients; reference to several current problems which patients demonstrate.

Care of patient with chronic ulcerative colitis.

Some suggestive causative factors in chronic ulcerative colitis.

Significance of psychogenic factors.

Demonstration of colonic irrigation for a patient with chronic ulcerative colitis.

Care of patient suffering from lysol poisoning. Review "suicide precautions."

UNIT V: *Nursing in Conditions of the Endocrine Glands and Metabolism*

1. Thyroidism

Demonstration of the basal metabolism test. Interpretation of its use.

Preparation of patient for basal metabolism test. Method of explaining test to the patient. Care of patient before and following test.

Care of patient with hyperthyroidism, with emphasis on care in thyrotoxicosis.

Care of patient with myxedema.

Occupational and diversional therapy for the hyperthyroid patient. Values in instance of individual patients.

Methods of assisting the hyperthyroid patient to obtain rest.

Pre-operative preparation. Use of iodide preparations.

Dietary treatment in hyperthyroidism and myxedema. Refer to needs, preferences, and problems.

Instruction required before patient's discharge. Need for medical supervision after leaving hospital. Contribution of medical social worker.

2. Diabetes

Care of a patient in diabetic coma, in insulin shock. Contrast the signs and medical treatment.

Instruction of the new diabetic patient during hospitalization, relative to disease condition, hygiene, insulin as a drug, administration of insulin, urinalysis, and diet. Method of recording this teaching.

Methods of calculation and administration of regular and protamine-zinc insulin dosage for several patients, using their syringes.

Method of testing urine for sugar and acetone. Demonstration of a positive test.

Method of calculating the diabetic diet and use of household measures.

Demonstration of diabetic foot care with lanolin and lamb's wool.

Review of instruction of old diabetic patient.

Laboratory tests used in diabetes: glucose tolerance, blood

sugar, and carbon-dioxide combining power tests. Preparation for test, normal test ranges, and the significance of rapid changes and high and low test results.

Function of the social worker in arranging for provision for insulin and follow-up visits.

Function of the public health nurse in the supervision of patient at home.

3. Other conditions

Care of patient with Addison's disease.

Care of patient with Hodgkin's disease during series of x-ray treatments.

Care of patient who has acromegaly.

Care of patient with pituitary hypofunction who is receiving oretone injections.

UNIT VI: *Nursing in Conditions of the Musculo-skeletal System*

1. Arthritis

Care of the bed patient with atrophic arthritis; with rheumatoid arthritis.

Methods of treatment with reference to comparative results in several cases.

Method of application and use of plaster casts. Problems involved.

Special regimen for the patient in the hospital and at home. Value, response to a planned routine.

Method of teaching the patient the use of sponges, pulleys, and other apparatus to correct spasticity or other disfunctions.

Method of teaching the patient the use of crutches, caliper brace, and the walker.

Diathermy treatment: preparation and care during treatment.

Suggestions for developing a healthy mental attitude toward limitations in arthritis.

Occupational and diversional therapies. Cite diversions which arthritic patients have enjoyed.

Medications used in arthritis, including sulfonamides, vitamins, salicylates, and gold salts. Benefits, dangers, and needs of individual patients.

Nutritional needs of the arthritic patient.

Discharge nursing instructions. Improvisation of hot wet packs for home use.

Rehabilitation of the arthritic.

2. Other conditions

Care of patient with gout.

Care of patient with osteoporosis.

UNIT VII: *Topics with Reference to General Medical Nursing Care*

Function of the medical social worker: agencies contacted for financial aid and rehabilitation, arrangements for placement at discharge of patients known to the students, significance of correct placement, methods of referral of patients to the social worker.

Use of community nursing services.

Significant variations between medical and surgical nursing care. Standing orders for the medical division.

Incidence of diseases in the medical division in contrast to incidence in this state and country. Diseases in the division which represent a major public-health problem.

Cost of medical hospital care and total costs of illness including convalescence and salary loss to the family.

Cost of supplies and drugs commonly used in the medical division. Administrative routine established for drugs charged to patients; cost of these drugs to the patient.

Care of patients with prolonged fever, with marked weight loss and malnutrition.

Technics of creating a pleasant atmosphere in the medical ward. Methods of maintaining quiet; frequent noises irritating to the patient. Consideration of the patient as a guest.

Understanding of the patient as a whole, especially in relation to his family and his community.

UNIT VIII: *Topics with Reference to Planning Nursing Care*

Consideration of individual needs and preferences of the patient.

Consideration of comfort measures during time medical treatments are given and during intervals between treatments.

Consideration of need for health instruction and instruction relative to medical condition. Plan for this instruction.

Need for guidance in making a plan for nursing care of the patient.

Values of close co-operation between the medical and nursing service.

Considerations in grouping the plans for care of several patients

into a pattern of work; for the 7:00 A.M.-12:00 noon period; for the 1:00 P.M.-5:00 P.M., 5:00 P.M.-7:00 P.M. periods; for evening care, for care during night.

Supervision of the student in planning her work for several successive days.

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PART TWO

Methods and Practices of Ward Teaching

Teaching Technics

THE FOLLOWING teaching methods or technics are given in the hope that they will stimulate the head nurse and supervisor to show variety in the use of methods. All of these methods will not be usable in any one institution. However, some understanding of the concept of the various methods as used in general education may lead to their use or adaptation in part or whole to ward teaching. Some nurses may feel that several of these methods do not apply to ward instruction but many have found them applicable. The selection of a method which is most advantageous from the standpoint of aims and outcomes is important. The head nurse should ask herself in planning the weekly ward-teaching program if the method selected is the best method of teaching the given subject matter. If *no* method seems adequate, a new method may be indicated.

A presentation of the discussion method and questioning as used in general education is included. These are fundamental practices in informal teaching and learning. Nurses should feel free to explore in the study and use of methods which occur to them or which arise in general education.

PART TWO

Methods and Practices of Ward Teaching

5

The Discussion Method

THE DISCUSSION method is that process or orderly procedure of learning and teaching in which a leader and group of students present and explain the pros and cons of a problem or issue in the light of the most authentic knowledge obtainable.

The method presupposes a good knowledge of subject matter by students and leader, the ability to use psychologic principles governing learning, and provision for sufficient time for arriving at adequate conclusions.

A Democratic Method. The discussion method is one of the most democratic methods. It provides an opportunity for each student to express herself. Expression helps the student to learn what she does and does not know. Discussion helps each student to complete her cycle of learning. She is pitting her opinion against that of the other group participants. Such a student is stimulated toward further study and thought as she has identified her position on an issue. Her feeling of worth increases. Discussion also helps the student to clarify her thinking and hence to clear up difficulties.

Students expect that the head nurse will accord them the privilege of discussion. It is an unwise head nurse that does not prepare in advance for a full discussion of any subject presented to the group. She may aid by supplementing the text through personal experience and by pooling the contributions of several students. She may also verify or test the value of student experiences. This helps to teach

the student to think of her experience as typical or atypical, to draw adequate conclusions and to form sound opinions.

Discussion helps to organize the abundant ward content into units of subject matter. Constant interpretation and cataloguing in correct relationship are essential. The head nurse may do much in constructive teaching by reorganizing the concomitant bits of information of the students. To do this, she must have free expression from her students. Lack of response may be due to lack of guidance, timidity, stage fright, fear of an audience, or lack of ability to express oneself in public. Teachers have set up many kinds of discussion methods which tend to decrease fear by increasing interest in subject matter.

The discussion period is a thinking period. If adequate preparation of the assignment is made, a beginning point for discussion has been afforded. An unprepared student retards both her own and the group development. The attitude should be created that both the leader and members of an informal discussion group may be expected to take an active part. "A discussion group leader does not consider his performance a success unless most of the group actively, that is, vocally, contribute in an attempt to make their own ideas and thoughts clear." * It is based on the thought that "regardless of the amount and correctness of the information upon which a person forms his conclusions, he cannot know what his conclusions are until he attempts to express them." * In the discussion group, "the emphasis is upon attempting to think with the material at hand." *

The group should number not more than twenty; a smaller group of ten or twelve is preferable. The chairs should be arranged informally about the room and in such a way that all of the group may see and hear one another without difficulty.

TYPES OF GROUP DISCUSSION

Thomas Fansler, in *Discussion Methods for Adult Groups*, describes several types of group discussion which are useful in teaching nursing care.

Type I Outline: To Form Decisions

Purpose: To study the problem at hand and to determine a course of action.

* Fansler, Thomas: *Discussion Methods for Adult Groups*, New York, American Association for Adult Education, 1934, p. 60.

To reach a decision which meets with group approval.

Leader: Head nurse or supervisor.

Method of use: In head nurses' conferences and committee work.

The purpose of this group is "to study the problem in order to work out a course of action, either individual action or co-operative action. . . . With this course-of-action type . . . the 'situation approach' is most applicable. The 'situation approach' is a method of presenting a problem as a special state of affairs, amounting almost to a crisis, involving study, decision, and action, in that order. Thus it can be seen that whereas this kind of group discussion may have resultant learning, the learning aspect is subordinated to decision and action." *

Type II Outline: To Understand and Interpret

Purpose: To interpret information or data relative to patients, procedures, and the ward situation.

To understand the complex factors involved in the solution of nursing problems of one or more patients.

Leader: Head nurse or supervisor.

Methods of use:

A. *Procedure*: Head nurse opens discussion with statement of topic, brief summary of aspects discussed previously, and present aspects for consideration. Discussion ensues with guidance. Head nurse summarizes aspects discussed, suggests further references, and closes period.

B. *Procedure*: Specialist or expert presents new idea or aspect of a problem for the group to think through, interpret, and discuss. The tendency in this method is indoctrination and the result is the adaptation of new information to the problems at hand.

The purpose of this Type II is to "explore, discover, interpret. If it can be said that the attitude of leader and group in the first type is, 'What shall we do?', then the totally different attitude in the second type may be expressed by the question 'How shall we understand?' " †

Example of Method A. This method is particularly adaptable to the ward conference on the problems involved in the nursing care of individual patients. We must recall that the main purpose of

* Fansler, op. cit., p. 61.

† Idem., p. 62.

the conference—actually a group discussion—is the understanding of the complex factors or aspects involved in the practical solutions of the nursing problems of one or more patients. A boy of seventeen years with chronic ulcerative colitis presents many aspects for care which must be explored, discovered by the nurse whose patient he is, and interpreted in terms of actual needs and indications for nursing care. The head nurse (the leader) opens the discussion with a statement of the topic, a brief summary of any aspects of care which have been discussed recently regarding this patient, and a presentation of the definite aspects which are under consideration at the present meeting. She asks a question, then *waits* for contributions. If none are forthcoming, she may address the question to a student, but this technic should be used sparingly. The head nurse acts only in a guidance capacity and the group discussion should progress actively as problems are considered. The more restrained she is in providing answers, the more fruitful will be the results.

When the discussion period becomes blocked, that is when no student is able to provide further contributions, the head nurse assumes leadership and aids the group in solving the issue. She may take over because of the shortage of time. She should hesitate to assume responsibility until some student thought has been expressed. She should not provide immediate answers, but rather project opinions to stimulate further thinking.

We are much too familiar with the type of discussion in which the leader seemingly knows and provides all the answers, and the students learn to listen without contributing. This is a lecture, *not* a discussion.

At the end of the allotted period, the head nurse sums up the various aspects discussed, may suggest further references, and closes the period. The discussion should not be permitted to dwindle or interest to lag before the group is adjourned. It is important from the standpoint of extending interest into activity to close the class while discussion and interest are high, and with a few questions yet unanswered.

Example of Method B. The leader is able through various guidance technics to direct the thinking of the group along particular channels of thought. Hence the amount of guidance is determined by the purpose of the discussion. Fansler says that "this method . . . is an excellent vehicle for indoctrination of all kinds

[and that] it is perfectly legitimate for use in many fields of study in which the goal is a rational acceptance of the reasons for carrying out a certain process in a certain way.”*

Type IIB is presented by a specialist or expert whose opinion the group will value. “. . . . The developmental method is applicable to groups who need the guidance of an expert who will isolate a new idea from a mass of evidence, state it clearly, and leave it with [them] to mull over at home until the next meeting. [They] depart with the feeling that [they] have learned something. . . . As [they] begin to progress consciously in [their] ability to grasp new ideas and interpretations, the need for this guidance grows less and the need for talking over new ideas develops. As [they] begin to fit the new knowledge into [their] individual scheme of life, then a hands-off policy on the part of the leader is more desirable.”†

The topic of a discussion group on the surgical isolation unit is precaution technic. Certainly, directing the thought of the group toward definite procedures is indoctrination, but it is permissive when presented from the point of view of the reasons for carrying out the procedure and the scientific study underlying these reasons. It must not be inferred that a discussion of technic in any way supplants a demonstration of technic. The discussion precedes or follows the demonstration of the actual procedure. It is the method by which we understand why we do what we do.

As another example, the students on a unit are interested in having the most pertinent and recent information about the vitamins. Research is being done and within the preceding six months new fractions of Vitamin B have been discovered. The doctor conducts a discussion group, presents the most recent information. The students leave the conference with new ideas and interpretations which within a few days they will fit into terms of their patients' vitamin needs and deficiencies.

Procedure When Class Consists of Students of Variable Backgrounds. When the ward group consists of students who have had variable experience backgrounds, the leader will need to give more guidance than when the members of the group possess similar characteristics. The third-year students tend to monopolize the discussion, which of course inhibits the first-year or junior students. All students need to be trained in the use of this method by actually participating in it. The leader may “pull out” the juniors when

* Fansler, op. cit., pp. 63-64.

† Idem., p. 64.

necessary by leading questions directed to them as a group or by indicating individual students to answer. The leader may take the correct or good aspects of a response and by a phrase of commendation, encouragement, or interrogation, assist the student in developing her own ideas on the particular aspect.

The more advanced student may have a tendency through relating personal case experiences to divert the discussion to side issues. Here the leader will need to center the discussion by repeating the major issue or by declaring that the most recent aspect is not the aspect under immediate discussion.

Again, if the third-year student is the kind which we refer to as the "lazy senior," who sits in judgment upon the responses of other students but does not herself participate in the discussion, the leader may direct a question which goes directly to the heart of this student's fund of information or experience. This is a question which this student, of all the group, is best able to answer. To get her talking on her interest often will make her a more active group participant. Once she has had this experience, she will be less prone to retire from the group.

Procedure When Class Consists of Students of Similar Backgrounds. It has been stated that in group discussions the amount of guidance from the leader is variable. A minimum of guidance is used when the group is composed of students from the same class in the school, and of comparable experience and background on a clinical service. The leader may present one thought-provoking question and within a few minutes the discussion is underway. It may be stated that the more experience the group has with this method, the more preparation for and responsibility they will assume in making the discussion successful. This method is satisfactory only when the head nurse makes assignments well in advance and ensures that the students come with a body of information pertinent to the discussion.

For example, the head nurse has chosen as a topic the use of digitalis and its derivatives in the treatment of Mrs. B., Mrs. G., and Mrs. A., three patients who are on the ward. She assigns several reference readings which represent the most authentic information regarding the medication, and requires the review of the case records. The head nurse had read these and other references and the case references before the discussion occurs. She also has a background of experience and information regarding the action of these drugs. However, with a comprehensive introductory question and little

assistance save direction of the discussion in line with the major issues, the head nurse participates to no obvious extent. She summarizes if a student does so unsatisfactorily, but in no instance does she take over until she is certain that no student is able to do it. To *wait* is difficult for the busy head nurse, but *waiting*, giving time for thought, and for the student to draw conclusions, is absolutely necessary and essential for the success of the method.

The head nurse also must have faith and confidence in the ability of the group to discuss issues. The old adages, "act quickly and unquestioningly," and "do as I say, not as I do," are not conducive to this method. Directing by commanding also does not contribute to the success of the method. Many ward classes and procedure classes have been "command performances." Perhaps the best criterion for the head nurse or supervisor to keep in mind in giving assignments for ward classes and in delegating students to participate is: "Does this take the form of a command performance?" Such methods may fulfil the required number of hours for ward teaching but these groups do not provide for adequate learning and tend to elicit the class sympathy for the victim-member. These classes create poor attitudes toward future ward teaching and mar the importance of the clinical content in the particular department.

Procedure for Use of Anecdotal Records of Patients. Another kind of discussion under Type II is that based upon case or anecdotal records. The head nurse determines in advance one or more patients in the ward who are the center of interest and who present similar learning aspects for the students. A student may begin the discussion by presenting the case history and major aspects of the record for consideration. After the presentation, the group discovers and discusses problems and possible solutions. A second patient is presented and discussed. The problems and solutions reached determine the pattern of instruction, which the student uses in teaching the patient.

Another good beginning is to have the student present the case record, then wait for discussion to ensue. Within a few minutes—although it is hard for the beginning head nurse to believe—a student asks a question, a student answers, and then the ball starts rolling. The head nurse permits the students to take as much responsibility in clarifying their thinking in significant aspects as is necessary. Then she projects a question or another aspect and again the discussion proceeds.

The head nurse presents the case when she wishes to set a pattern for method of presentation or occasionally with advanced students when she wishes to test their information. In the latter instance, she may omit several significant details or an aspect fundamental to a decision regarding the problems of the case. This stimulates the students to question her, to follow the case more carefully, and to realize the significance of complete data. Some student may make a quick solution and be challenged by another nurse. The entire class soon begins to think through the case and its implications. The head nurse will need to use skill in maintaining free discussion, in not discouraging the student who fails to think clearly on a situation, and in continuing a wholesome class attitude. This method is just as difficult as it is interesting, and is a good modification of the usual procedure. The head nurse must lead and center the discussion; she cannot follow it and participate only inactively; she must be ready at every turn to supply information, to bring out or to illustrate a significant point.

A variant of Type II may be used as a summary at the end of a week devoted to a study of the various aspects of a problem or condition. This is effective only if the members of the group have attended every class for that week. The head nurse begins the hour by summarizing the major aspects of the previous meetings, the facts discussed, and the conclusions reached. Next she asks the group to present their readings or observations relating to the topic. It serves as a good summary, assures class interest and participation, and implies that new ideas will develop from previously gained information.

There are several dangers which the head nurse should guard against in the use of the discussion method:*

1. Interest in process rather than in the real aim.
2. Counterfeit socialization: substituting pupil for teacher.
3. The officious and domineering attitude.
4. Shirking individual responsibility.
5. Intellectual rambling and futile discussion.
6. Lack of thoroughness.
7. Anti-social feelings and conduct.
8. Perfunctory routine.
9. Excessive social pressure.

* Robbins, Charles: *The Socialized Recitation*, Boston, Allyn and Bacon, 1925, pp. 62-72.

10. Failure to comprehend the real meaning of the socialized recitation.

Safeguards in Use of Case Method of Presentation. There are several safeguards in the use of the case method and as this is one of our most important methods in teaching nursing, these precautions should be understood.

1. The student needs direction in abstracting the pertinent information from the case record. By conference in advance, she may be guided in deciding which elements are significant. She needs to know how much laboratory data is to be included, which diagnostic tests are significant in the case and condition, how much social history is relevant in relation to diagnosis, whether this condition represents a community problem, and several of the situations that might be typical or atypical for this patient with this condition.

2. The presentation as such should serve as a basis for or lead up to an active discussion group. The student should understand this in her period of preparation. In no instance should the presentation of one student be characterized as: "Presentation of a case, its problems and their solution, and dismissal without discussion." This infers no need of discussion, that the nurse knows all the answers, and that the case is relatively simple and like all other cases that she has seen and nursed. The real truth is that the student is doing superficial nursing.

3. The students should be permitted to describe similar anecdotes or cases for which they have cared only if these previous patients are recognized by the head nurse to present similar problems or situations which clarify the present one, and actually have been under the direct care of the student describing them. Most students rarely remember all the significant facts of previous cases and hence, in telling them, omit major aspects.

This may be provided for by asking the students who have given care to similar cases to come prepared to present briefly the major aspects from a complete nursing-care report or study. Discussing patients not known to the majority of the group should be avoided.

VALUE OF TWO LEADERS

It is helpful, when possible, to have a second head nurse or supervisor present to augment the discussion with the latest information, make sure that interpretations are clear, and really act as a second

leader on the same level as the first. Less often will discussion be blocked because of incomplete facts and the group adjourned to look up further references. Groups like up-to-the-minute information. It is "news" to them. The two leaders try to avoid having a conversation between themselves but co-ordinate in stimulating discussion and in questioning the student in an effort to help her formulate her own ideas more clearly.

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6

Questioning

ALL TEACHING and learning involve questioning. This is a difficult though highly useful art. The two common types of questions are fact questions which call for specific information and thought questions which provoke consideration of relationships or the association of ideas.

FUNCTIONS OF QUESTIONING

*The functions of questioning have been stated well by Bossing.**

- "1. To test student achievement.
 - a. To discover to what extent the student has mastered the essential facts in the lesson.
 - b. Testing of student understanding of these essential facts as they pertain to the lesson or situation.
2. To aid the student to relate pertinent experiences to the lesson.
3. To stimulate interest.
4. To provide drill.
5. To stimulate thought.
6. To develop the power and habit of evaluation.
7. To ensure proper organization and interpretation of materials and experience.
8. To direct attention to significant elements in the lesson.
9. To obtain individual or class attention.
10. To discover interests and establish rapport with students.
11. To develop appreciation.
12. To provide direct incentive for study."

* Bossing, N. L.: *Progressive Methods of Teaching in Secondary Schools*, Boston, Houghton Mifflin, 1935, pp. 288-295.

The characteristics of a good question are as follows:

1. Specific and definite.
2. Within the comprehension of the students.
3. Not answerable by yes or no.
4. Unambiguous.

TYPES OF QUESTIONS

Questions may be worded as a complete sentence or as a partial phrase. Both are stimulating and are considered satisfactory if they are stated clearly. In asking questions, consider the type of question in relation to the procedure. If a fact question is asked, and the purpose of the period is the testing of information, state the question in an easy, confident manner, allow a short pause, then designate someone to discuss it. The class may be rotated quickly or the questions may be distributed promiscuously.

If a thought question is asked, state the question, then pause, allowing a sufficient time for the formulation of an answer; ask for a show of hands of those prepared to answer it, then select a student to respond. Request other points of view or different answers to the same question. Discuss the answer but do not repeat the individual student answers. This latter procedure tends to have the students listen only to the head nurse rather than to the students' contributions. Occasionally, it is beneficial for the head nurse to summarize the discussion to date, or to repeat a part of an answer for the purpose of reinforcing it. This helps to center class attention on the question at hand, provides an opportunity for all students to prepare a tentative answer, and hence makes the group skeptical of the answer of the individual student.

If a student presents a richer background, she may be called upon to contribute, particularly when a discussion is blocked. However, on the basis of her further knowledge she should not provide immediate answers to thought questions or discourage group discussion. The position of such a student in the group may best be arrived at through an individual conference with the head nurse. She may be made aware of her superior knowledge, the instructor may ascertain how she obtained it—through reading or a special course—and suggest that she co-operate in promoting the desired degree of class discussion. She should be called upon often enough to maintain her interest.

Each student should be permitted to participate when this method

is used. The head nurse must be fair in designating the students who are to respond. This is one aspect of the democratic method.

In response to thought questions, complete answers should be expected. Do not accept fragmentary or partial answers, but rather repeat the question, allowing further thought. Insist that the student organize her answer in a coherent, logical manner. General answers and the use of such expressions as "naturally" and "of course" should not be permitted. These are attempts to cover ignorance. On this page is given a partial list of expressions which were used by teachers in general education. This may be suggestive to the head nurse in improving her questions and in providing phrases useful in conducting ward classes. A careful study of this list will be of extreme advantage in creating a positive attitude toward teaching.

EXAMPLES OF POOR EXPRESSIONS AND QUESTIONS

Poor expressions and questions will be negativistic, casual, condescending, and marring to the initiative and thinking of students. The following list, taken in part from a long list, suggests many expressions for the head nurse to avoid.

LIST A: *Some Expressions Used by Poor Teachers Not Used by Good Teachers* *

"A little twisted at the beginning

Anything wrong?

Are you working hard?

Aren't you ever going to learn to spell that word?

But why not?

Did she have all her facts straight?

Don't get her excited

Don't get too noisy

Don't let this go over your heads

I am afraid you are confused

I didn't understand what you said

I didn't see that statement in the text

I thought so

I suppose

Indeed

* Barr, A. S.: *Characteristic Differences in the Teaching Performance of Good and Poor Teachers of the Social Studies*, Bloomington, Public School Publishing Co., 1929, pp. 40-48.

Is what?
 Let's have it again
 Listen
 Maybe
 Naturally
 Next topic
 No, it isn't that
 No, that's wrong
 No, that isn't right
 Now, come on
 Now, don't be modest
 Oh, dear, don't you know that?
 Oh, never mind
 Say something
 That all depends
 That isn't all I want to know
 That's the way it goes
 That's exactly wrong
 Well, of course
 Well, that depends
 Well, that is hard to say
 Well, what about it, etc.
 What?
 What are you trying to tell me?
 Why didn't you think of that before?
 You are wrong
 You listen while I tell you"

EXAMPLES OF GOOD EXPRESSIONS AND QUESTIONS

Good expressions and questions are positive, stimulating, encouraging, create hope, and urge the student toward reflective thinking and sound judgments. The following list, taken in part from a much longer list, suggests many expressions which the head nurse may use in conducting informal discussions.

LIST B: *Some Expressions Used by Good Teachers Not Used by Poor Teachers* *

"A good thing to know
 Aha, there's a new idea

* Barr, op. cit.

All right, I'll accept your statement
And what more?
Are you just going to accept that answer? I should like more proof
Are you satisfied with that statement?
Ask the class
Better change your mind about that
But there's another point
Can you prove the statement?
Can't you supply a better word?
Certainly
Cite references
Does that answer my question?
Does that suit you?
Don't be too easily discouraged
Don't you really think you could?
Exactly
Good question
I am glad you remembered that
I am sure you can answer that question
I'm anxious to know about that
I'm afraid this question can't be settled
I'm certain that you know
I don't know about your first point
I don't know, that would be worth looking up
I don't believe so
I had thought of that
I think we will leave that topic right there
I think so too
I think there's another point
I think that's an important point
I think the class will be interested, etc.
I wonder if that is really true
Is that your point?
Is there more discussion?
Let's get an example
My mistake
Now be careful
Now you are on the right track
Oh, don't you remember?
Oh, I misunderstood you
Oh, I think you could

Part of your statement was not quite right

Please

Precisely

Surely

Tell me that in a few words now

Tell us a little more about that

Thanks

That's a good question

That's another point all right

That's interesting

That's very good

That doesn't tell us very much

That is a rather hard question

That is much better

That may be true

That would be very interesting

Then you would say

There's a difference of opinion

Usually

Very nice

What difference does it make?

What you say is true but it doesn't answer my question

What's your opinion?

Where could you find that information?

Who do you mean by "they"?

Who will help out?

Yes, I think so

Yes, I think you are right

Yes, of course

Yes, perhaps

Yes, that's right

Yes, that's the point

Yes, that's good

You have the idea

You had better look that up

You must have read incorrectly

Your statements are correct, except, etc."

THE TEACHER'S ATTITUDE IN QUESTIONING

The head nurse's reaction to the student's response to a question is significant in promoting good class discussion. Bossing suggests five teacher's reactions applicable to such situations.*

- "1. Show appreciative attitude toward student response.
2. Interpret sincere response to the advantage of student.
3. At times it is desirable to get class evaluation of partially correct responses.
4. As a rule, students should not be assisted in response.
5. Responses should be couched in complete thought units and be correct grammatically."

The beginning teacher will do well to write out the questions which she intends to include in her lesson plan or outline, to ensure variety, correct and complete wording, and confidence in the use of the method.

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* Bossing, op. cit., pp. 310-312.

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7

The Group Conference

USE OF THE GROUP CONFERENCE

THE GROUP conference is our most commonly used method of ward teaching. According to Webster, the term conference is defined as "an interchange of views, formal consultation, or discussion." The major purpose of the conference is to counsel, consult, compare, and to advise. "The term 'conference method' implies that there is a way of exchanging experience that is in and of itself education. . . . Conference planning that does not somehow arrange for an actual and free exchange of knowledge and experience represents a plot, not a plan." * The understanding and use of the technic of the discussion method and questioning are basic to a good group conference.

The purpose of the conference is not to hear what more accurately might have been read, but to discuss a problem or situation of interest to those present. The head nurse in planning her conference material should devise a more logical method to provide for mastery of related but non-conference materials.

Whenever the group interest and response is lagging or lacking, the head nurse should analyze first the *subject matter of the conference*, then the *use* of the conference method, and lastly the *students' background* of education and experience in relation to the content and method.

The group conference is used to present the following types of learning material:

1. Completely or partially new information about a patient.

* Ely, Mary L.: *Adult Education in Action*, New York, Amer. Asso. for Adult Education, 1936, p. 400.

2. Review material regarding a patient wherein the purpose is summary or drill.
3. Progress conference or report concerning several of the patients on the ward.
4. Information which a new nurse coming to the ward for the first time needs to know.
5. Information which several nurses returning to the ward after an absence involving a change of patients or routines need to know.

The following classification of the group conference is given:

1. Morning and evening report.
2. Nursing care and needs of a particular patient.
3. Discussion and summary following morning rounds.
4. Orientation of new nurses to the division.

MORNING AND EVENING REPORTS

The *morning report* is held when the nurses come to the ward or shortly after their arrival, for example, at 6:55, 7:00, or 7:05 A.M. in or adjacent to the ward or division in which the patients are placed. The room or site for the report should be prepared in advance, with adequate seating provision for the nurses who are to attend. The preparation of the room may be made on the previous evening, or by a night subsidiary worker, by a classroom monitor, or less desirably by the night nurse. It should not become the responsibility of the nurse who just happens to arrive on the ward a few minutes early. A teaching room adjacent to the ward, an internes' laboratory which is not in use, a treatment room, a large linen-room, an enclosed porch or visitors' room, the end of a less frequently used corridor, or any quiet, isolated space may provide adequate space for the morning report conference. The nurses should not gather around the head nurse's desk, at which are located the telephone, the medical orders, and the sources of administrative information. Attention cannot be held at this focal point.

A definite report procedure may be arranged to advantage. The report should begin promptly at the time agreed upon, with all nurses seated and attentive. No nurse engages in a second activity such as charting during the report procedure. The head nurse who arranges to be in the teaching room a few minutes ahead of the group may be able, as the individual nurse enters, to glance at or inspect her appearance as a ward worker. The night nurse reads



FIG. 5. The group conference on the surgical ward. This room was planned and equipped as a ward classroom. Note the desk shelf which may be lowered, the collapsible chairs, the wall charts, and the blackboard. At the opposite end of the room is a spot map of Massachusetts, a bulletin board, and a closet for teaching materials.

the report in a clear, concise manner. The head nurse asks questions concerning the patients and their care. As the report proceeds, the students and staff nurses ask pertinent questions about their patients which either the night nurse or head nurse answers.

The head nurse should be seated away from the night nurse. Otherwise the report may become a tête-à-tête between these two individuals with little command of attention from the others present. The report should be interesting enough to hold the attention of the group. It is a wise head nurse who discusses with the unit supervisor the significant content for the morning report. Certainly this daily activity may be evolved into a more educational process. It should be approached as a learning situation and increase in educational values. On this basis it seems most advantageous to report in detail regarding the acutely ill patients, their condition, their reactions, and the nurse's interpretation of these reactions, the nurse's observation, the exact hour at which the doctor was notified and arrived, and the assistance sought from the night supervisor. The convalescent patients who received no medication and slept well may be summarized as a group. The night nurse reports, in writing, any shortage of supplies, any supplies borrowed or loaned, and the ward with which this transaction took place.

If a treatment sheet or Kardex system is used for listing nursing orders, it may be possible for the night nurse to give her report from these forms. She writes brief remarks following each patient's name. This avoids the necessity of a more detailed night report.

Following the night nurse's presentation, the head nurse may ask in summary for the names of the patients who are to be operated upon and who have been prepared to have special tests or treatments. She may announce who is to be discharged and give any specific administrative instructions which are of interest to the entire group. These should be worded in positive form. The entire nursing group should not be notified of what one or two nurses are failing to do. A negativistic attitude should not be tolerated. Unless some few questions are asked by both students and head nurse, the report tends to lack interest and to become routinized. Whenever questions are not forthcoming, the head nurse should look to her report procedure. This must be vitalized by the head nurse's attitude and eagerness in beginning the day's plan of work.

The *evening report* is the one group report which the head nurse gives. The morning report she only receives. Hence the evening report is her standard-setting report. At this time, by example, she

teaches the nurses how to give a good report, i.e., what the report should and should not include, the need and facilities for advice and assistance, observations to be made, untoward symptoms to watch for, the results and comparative effects of hypnotics administered by other nurses on the previous evening, and a few principles of work planning and ward management.

When the care of the patients permits, the student nurses' program should be arranged to permit attendance at the evening report. Here an opportunity for summary of the patients' conditions is afforded and the results of treatments and tests performed within the last 12 hours are explained. Hence the pattern of treatment and care is made continuous and more logical in the thinking of the student. This report may occur between 6:00 and 7:00 P.M. There is no particular reason why it should be given only at 6:50 o'clock, hence projecting any discussion into the free or off-duty time of both students and head nurse. In a hospital in which eight hours of consecutive service is provided, the report may occur at 2:30, 3:00, or 3:30, when the change in nursing service occurs. Certainly an adequate time provision is an essential factor in the success of any discussion method.

NURSING CARE AND NEEDS OF A PARTICULAR PATIENT

The group conference which centers itself around the nursing care and needs of a particular patient represents our most commonly used method. This conference should meet the five objectives of ward instruction (see page 4), should be of excellent quality, positive in approach, and pertinent.

This type of group conference has replaced the more generalized conference regarding, for example, the nursing care of asthmatic patients as a whole, the discussion of erythema nodosum as a disease condition, the use of sulfathiazole as a new drug, or the first-stage gastric diet as a dietary procedure. There is no place in the ward-teaching program for these more general discussions and conferences. This type of material may be presented more economically by the lecture method in a more formal class or by reference reading.

Indeed, aspects of these topics will be considered, but in relation to their specific use or application in the care of a patient who is known to the students. Teaching which is not centered in this way about a patient loses its zest and interest. The purpose of these conferences is *to improve the nursing care of one or more patients.*



FIG. 6. The social worker conducts a group conference regarding the home situation of a patient suffering with a peptic ulcer. The public health nurse and head nurse attend to assist in interpreting the nursing problems. The medical staff room is used for informal discussion groups.

To fulfill this purpose, the students must need and want to know the patient, have read the case record, have need of this information, and be in a position to apply the learnings resulting from the conference. This is human interest material which we know has a tremendous interest value to students. As we are able, through these conferences, to increase and develop student insight into patients' needs and problems, in this same proportion the student's foresight, reasoning, and understanding will be manifest in the quality and intelligence of the nursing care. Skill in practice is another quite different aspect. Here we are concerned with the development of an active interest in the patient's needs which we hope will be followed by increasingly intelligent action.

From another point of view, this group teaching is subjective; subject matter presented in the more formal courses is more often objective. It is subjective in that each nurse participating—and we anticipate that they all will be actively present—may project her point of view regarding the patient's reactions, that is, what she has observed, what the patient has told her, what the family has remarked, and what she has sensed to be the patient's needs. The cumulative material of the head nurse inherent in her experience may be in part subjective. The fact that this is material which the nurse will be unable to obtain in any other way gives real motivation for attention, makes the student able to give active mental participation, and demands a mental response. The more intelligent and psychologically sound our method of presentation, the higher the interest rate and the more dynamic the nursing care. In this type of conference lies the crux or cross roads of professional nursing. The more highly developed the teaching technic of the head nurse, the more rapidly the nursing care rises to a professional basis. Before us in this whirl of human interest surges the patient's immediate needs, the comfort measures, his nursing and personal problems and the plan for solving these problems, the health teaching of the patient, his convalescent and discharge instructions, the family instructions, and the health program for the family. This thing called nursing is broader than one or two nurses, the wards, the doctors, or the hospital. It is not an isolated entity, but extends from illness and the hospital to everyday living in every community. And so in a group conference regarding nursing care, we plan for a patient in such a way that he may not only recover most skillfully and uneventfully, but also that he may live uneventfully as to illness and vigorously as to health. The interest in teach-

ing should be so excellent that when a patient returns for another period of hospitalization or to the out-patient clinic, we should take this opportunity to discuss the problems of convalescence with the patient. It should be challenging to have the patient criticize our previous convalescent teaching.

Several factors should be considered in planning and conducting the group conferences regarding nursing care.

1. Patient should be present in the ward and known to the students who attend the teaching.

2. Teaching should be of importance to all students who attend.

3. Students should read the case record before attending the conference.

4. On the whole, the patients discussed should represent the usual ward experience (ward analysis of value here); special resources in regard to cases should be utilized.

5. Topics should be limited in scope. A small area of the problem should be considered carefully rather than several aspects more superficially.

6. Criteria for the selection of content are relevancy, frequency, within learning capacity of students, practicability, and clarity.

7. Criteria for the correct use of this teaching method are quality and amount of discussion. A head nurse should not continue to use, in the same way, a method which does not arouse discussion.

8. Teaching should show progression. Simple, uninvolved cases form the basis for discussion by the first-year students, while more difficult cases with intricate problems form the basis for third-year discussions.

EXAMPLES OF CONFERENCES REGARDING NURSING CARE

I. *Nursing Care of a Patient with Asthma*

POOR CONFERENCE

NOTE: This conference was presented for discussion at a head nurses' conference on teaching methods. This example is poor, as it violates several important factors essential to the correct use of the group conference method. Time—15 minutes.

SUBJECT MATTER

ANALYSIS

Head nurse: "Today we're going to discuss the nursing care of Mrs. R. who went home last week. As we know, Mrs. R. was on the ward for two months with asthma.

First let us briefly review the disease. Asthma is a disease characterized by dyspnea of a wheezy type, due to the spasm of the bronchial muscles and edema of the mucous membrane, lining the bronchial tubes.

How many have read Mrs. R.'s history? Unfortunately the record had been returned to the record room when I posted the assignment last night.

Miss L., suppose you tell me what you remember of her history.

(Student gave various general facts.)

As a result of this disease, what would you expect her x-rays to look like?"

Student: "The thoracic cavity would show a definite deformity."

Head nurse: "Who can tell me why a patient comes to the hospital with asthma?"

Student: "For rest and treatment."

Head nurse: "The room of the asthmatic patient requires spe-

Violates Factor 1. Patient should be present in the ward.

Violates Factor 2. Teaching should be of importance to students who attend. Patient will not profit from a presentation of this case.

Violates Factor 7. Head nurse presents material which might better be obtained through questioning. Disregards law of recall.

Violates Factor 3. Students should read the case record before attending the conference. Assignments should be posted several days in advance, as time is required for several students to obtain and read the case record.

Question is too broad and not specific. Data given will be based entirely on memory. When x-rays are discussed, they should be at hand and used as a teaching aid.

Student's answer is not discussed or made more specific.

Question is too broad and answer is not pursued further.

Violates Factor 6. One criterion for the selection of content is

SUBJECT MATTER

cial preparation before the patient is admitted. It also requires special care while the patient is in the hospital. It should contain little plain furniture, no overstuffed furniture, no drapes. Wet mopping and dusting are important. The room should be warm, dry, sunny, and well ventilated, avoiding extremes in temperatures and draughts. The mattress should be air or cotton-stuffed. Feather pillows should be covered with rubber pillow cases.

What is the general appearance of the patient on arrival in the ward?"

Student: "The patient is fatigued, wheezes constantly, and seems completely exhausted."

Head nurse: "The care of the asthmatic patient on the ward includes rest and relaxation, bed and chair, regular elimination, and diet. The latter must be explained carefully.

What additional supportive measures are necessary?"

Student: "Back care, mouth care, occupational therapy, and reassurance."

ANALYSIS

clarity. Material is not presented effectively. Statements are general and are not related clearly to Mrs. R. Reasons for the special preparation of the room are not given.

Violates Factor 2. Teaching should be of importance to all students who attend. The question as stated might refer to Mrs. R. who was admitted two months ago, or to any asthmatic patient who might be admitted. It is indefinite.

Violates Factor 5. Topics should be limited in scope. A small area of the problem should be considered carefully. The statement is made that the diet must be explained carefully; however, the head nurse gives no detail about it. This diet is very detailed and represents specialized information.

If this conference was actually about the nursing needs of Mrs. R., such general answers could not be accepted. There is no question about the specific needs of one patient or in-

SUBJECT MATTER

ANALYSIS

Head Nurse: "We won't discuss the medicines used, as they are too numerous to mention at this time.

What about the patient's nursing care? We must teach good personal hygiene such as rest, proper diet, regular elimination, and mental and physical relaxation.

What are the nurse's duties in relation to the above? She must make the patient comfortable during and between attacks. High headrest with knee rest and cardiac table on which to rest the arms. If patient tires of bed he must be put in chair with sufficient clothing to prevent chilling. Since these patients perspire profusely, it is better to have them wear a flannel nightgown. The patient's diet must be watched carefully. Foods must be watched for reactions. The special elimination diets are inconvenient for the patient, especially if he must eat away from home. Heavy meals and solid foods exaggerate attacks."

sight into the details of nursing care.

Violates Factor 6. Content should be relevant. Consideration regarding medication, which is one of the most significant aspects of nursing care, is not discussed.

Question is not specific and is indefinite. No pause was allowed for answer or discussion. Again the answer does not relate to Mrs. R. or another patient in particular.

Question is not stated clearly. It is not used as a question but as an introductory phrase since the head nurse proceeds to give the answer. The reasons for the various aspects of care are not given.

Comments: This conference violates Factor 7. The quality and amount of discussion are questionable. It shows little

SUBJECT MATTER

ANALYSIS

preparation and presents no further content than would be given in the more formal course in Medical Nursing. The conference would be of little or no value.

II. *Nursing Care of a Patient with Asthma*

GOOD CONFERENCE

NOTE: This conference is given in contrast to Example I. It was presented by a head nurse to first-year students. Time—30 minutes.

SUBJECT MATTER

ANALYSIS

A. "Brief review of disease.

Provides for Factor 4. Asthma is a significant medical condition of fairly frequent occurrence.

1. Asthma is a disease characterized by dyspnea of a wheezy type, due to the spasm of the bronchial muscles and edema of the mucous lining of the bronchial tubes. It occurs in sensitized persons and may be caused either by intrinsic or extrinsic factors.

Head nurse begins with the disease condition. Another more interesting introduction is a description of the patient as a person. She will progress from the general to the particular in her presentation.

a. Intrinsic asthma is that type which is caused by some factor within the body such as foci of infection or emotional disturbance.

b. Extrinsic asthma is that type which is caused by some external element such as dust, foods, and pollen.

B. The asthmatic patient comes into the hospital for two reasons.

SUBJECT MATTER

ANALYSIS

1. Controlled environment enables the doctor to determine the cause more readily.

2. The hospital tides the asthmatic patient over an emergency which the family doctor may have been unable to control at home. This was the reason why Mrs. G. came to the hospital.

C. Preparation and care of patient's room. What special preparation was given to Mrs. G.'s room on admission and how is it cared for?

1. Few pieces of plain furniture.

2. No overstuffed furniture, heavy drapes, or curtains.

3. Wet mopping and dusting.

4. Warm, dry room, well ventilated and sunny.

a. Avoid extreme draughts and extremes in temperature.

b. As free from dust as possible.

5. Avoid disinfectants used in cleaning.

6. Cotton-stuffed or air mattresses and pillows. Patient has an air mattress.

a. Feather pillows should be covered completely with rubber pillow cases.

D. Appearance of Mrs. G. on arrival in the ward, and the nurse's observations.

SUBJECT MATTER

ANALYSIS

1. Patient sitting upright in bed, leaning forward on folded arms with shoulders elevated and fixed by firm support to elbows or hands. Why does patient assume this position?
 2. Inspiration is short and spasmodic, accompanied by throwing back of head.
 3. Expiration is prolonged, the muscles slowly force the air from the chest. Cough is used as an expiratory aid.
 4. Perspiring profusely. Why?
 5. Cyanotic. Why?
- E. List of treatments ordered by the doctor. (Written on blackboard.) The medications will be discussed in a few minutes.
1. Bed.
 2. Fluids ad lib.
 3. Adrenalin \mathfrak{m} VII stat.; adrenalin \mathfrak{m} V q $\frac{1}{2}$ h, p.r.n. for asthmatic attacks.
 4. Potassium iodide \mathfrak{m} XV p.o. t.i.d.
 5. Potassium citrate 25%, 51 p.o. t.i.d.
 6. Ether 51 in olive oil \mathfrak{z} II p.r. for severe attack unrelieved by adrenalin. (Indication for use and type of action?)
 7. Special elimination diet. (What are the constituents?)
- F. What physical comfort measures would you deem ad-

Head nurse describes position on admission, as the students were not present.

Considers Factor 7. This leading question provoked free dis-

SUBJECT MATTER

visible on the admission of Mrs. G.?

ANALYSIS

cussion from three students who had cared for the patient.

1. High headrest support with pillows; cardiac table with pillow tied over the top.

2. Clean, dry flannel nightgown.

3. Oxygen with B.L.B. mask (closed).

a. Why use a closed mask?

b. What care must patient's nose and throat be given when receiving oxygen?

G. What mental comfort measures are necessary during an attack?

1. Reassurance strengthens effect of medicine.

2. Nurse must remain calm and quiet.

3. Problem of over-talkative nurse.

4. Reassurance of family.

H. General nursing care of a patient with asthma.

1. Bed with cardiac table.

2. Back care without powder. Why? Patients frequently have severe pain in back and along line of diaphragm due to muscle fatigue, hence careful, slow rubbing across posterior thorax is important.

3. Nose and throat care.

a. Mrs. G. breathes through mouth.

b. Keep nares oiled and clear to facilitate breathing.

This question calls for specific information. Considers Factor 1. Patient should be present in the ward and known to the students who attend the teaching.

SUBJECT MATTER

ANALYSIS

- c. Prevent infection of nose, throat, and sinuses by isolating patient from others who have respiratory infections.
- 4. Frequent baths. Patient perspires profusely.
- 5. Flannel nightgown. Why?
- 6. Diet. (Constituents of the asthma diet will be discussed on Friday.)
 - a. Thorough explanation of diet to patient and importance of adhering closely to it.
 - b. Inspection and washing of fruit brought in by visitors.
 - c. Importance of gaining co-operation of family.
 - d. Light, frequent, attractively arranged trays.
- 7. Elimination.
 - a. Importance of habit time.
 - b. Gas against diaphragm embarrasses respirations.
- 8. Diversion.
 - a. Occupational therapy—painting.
 - b. Reading.
- I. Medical treatment.
 - 1. What are the means of determining patient's sensitivity to extrinsic factors?
 - a. Diet.
 - b. Skin tests.
 - 2. Drugs used in treatment of asthma.

Should have brought out the effect of secondary infection on Mrs. G.

Considers Factor 5. A small area of the topic should be considered carefully. In the field of medical treatment, drugs which are important for the student to administer are considered in detail.

Considers Factor 2. As attacks occur without warning, instruc-

SUBJECT MATTER	ANALYSIS
a. Immediate response.	
(1) Adrenalin 1-1000.	tion about the use of emergency drugs for Mrs. G. is important information for all students in the ward.
(Epinephrine.) (What measures must the nurse observe when giving?)	This question helps to correlate subject matter in Materia Medica with the use of the drug for Mrs. G.
(a) When and how given.	
(b) Action and dosage.	
(c) Importance of massage of injected area.	
(2) Adrenalin 1-1000 nebulizer.	This section should provide more information about the patient's response to the various medications.
(a) Shrinks mucous membrane.	
(b) Constricts blood vessels.	
(c) Sprayed on larynx and inhaled.	
(3) Aminophyllin 10 cc. intravenously.	
(a) Given intravenously by house officer.	
(b) Importance of sterile equipment at bedside.	
(4) Ether in olive oil.	
(a) Fewer patients allergic to olive oil than cotton-seed oil.	
(b) Give very slowly with catheter.	
(5) Oxygen with B.L.B. mask or tent.	
(a) Nursing measures to be carried out with patient getting oxygen by mask.	
(b) Nursing measures	

SUBJECT MATTER

ANALYSIS

with patient getting
oxygen by tent.

b. Prophylactic response.

How do the doses given
for immediate and for
prophylactic response
vary?

(1) Adrenalin in peanut
oil.

(a) Action lasts from
9 to 16 hours.

(b) Advantages of
drug: Longer action.
Less frequent injection.

(2) Ephedrine.

(a) Prevents paroxysms.

(b) Relaxes bronchi.

(3) Potassium citrate.

Why is this drug used?

(a) Relaxes bronchi.

(b) Toxic symptoms:
Nausea.

Vomiting.

Diarrhea.

c. Expectorants—potassium
iodide. (What is the
particular effect in asthma?)

(1) Increases fluidity of
secretions.

(2) Increases flow of mucus.

d. Drugs given infrequently.

(1) Morphine sulfate—
depresses cough reflex.

(2) Atropine sulfate—
dries secretions.

SUBJECT MATTER

ANALYSIS

J. Summary questions.

1. What observations concerning patient's attacks are important to report to the doctor?
2. What part can social service play in the patient's care while she is in the hospital?
3. How will this disease interfere with the patient's occupation?
4. What must the patient be taught before discharge?"

These questions give a different consideration to the patient and her problems.

Summary: This conference considers Factor 8. Simple, uninvolved cases form the basis for discussion by first-year students.

This conference would have been improved by more detailed data regarding the patient's reactions to treatment and response to nursing care.

SUMMARY FOLLOWING MORNING ROUNDS

Morning rounds refer to the medical visit of the internes, visiting doctors, consultation service, or to the visit of the student nurse to the bedside of several patients with the head nurse or supervisor. The medical round holds little educational value to the student nurse unless it is followed by an explanatory conference. The reason for this is inherent in the major purpose of the round. The doctor visits the patient to observe his condition—that is, especially his medical condition. The patient's nursing condition is a secondary consideration for the doctor. The student may learn through rounds the signs and symptoms which the doctor observes, and his interpretation of the findings. How much educational value these gleanings may hold is conditioned by the nurse's previous background in the clinical field, her ability to fit the information into the picture, and the teaching interest of the doctor.

Indeed, the student may appreciate more fully the extensiveness of medical care and treatments, the tremendous number of factors which the doctor needs to consider in making a correct diagnosis, the purpose and need for a differential diagnosis, her importance in observing and recording data accurately, the extensive use of laboratory facilities, and the objectivity of the doctors in medical care and research. These appreciations, however, are categorized and affirmed only through conference following rounds. Such expressions as, "Do you recall," "What was the meaning," "Why do you believe," "Can you interpret," help the student to confirm these subject-matter associations.

To permit or send a student on medical rounds as part of the ward-teaching program, without providing an opportunity for conference is not educationally sound. It gives rise to confusions and incorrect interpretations. The student departs from rounds with a tremendous respect for the subject matter, knowledge, and skill of the physician, but with little or no addition to her nursing knowledge.

This applies equally well to the rounds which the head nurse makes with the night nurse in the morning, or which the supervisor makes with the student nurse. The purpose of these rounds is not solely inspection, for inspection of a unit relates chiefly to the housekeeping ability of the nurse. No one aspect of care should have such predominance of attention. Observation of the patient may show whether or not he is in a comfortable position, if the nurse has cared for his eyes, hair, mouth, and hands, if fluids have been offered and if diversional therapy has been suggested. Morning work or nursing care cannot be evaluated adequately by rounds. The head nurse or supervisor will need to sit down with the student and discuss the bedside picture. This kind of conference can be most satisfactory when the assignments of students to patients have been carefully planned, the assignment well motivated, and on-duty time used for this conference. To plan for conferences in students' free time in some instances erases all interest in the conference material.

The question frequently arises as to whether rounds with the doctor, that is, the student joining the medical group to hear discussions or comments regarding her patients, should be considered planned ward teaching. This is a kind of ward learning and certainly the student should have this privilege. However, this is not planned group teaching and should not be tabulated as such.

ORIENTATION OF NEW NURSES TO THE DIVISION

An orientation conference should be provided for each student reporting for duty in the ward for the first time or after a period of absence during which the patients and routines have changed. The procedure for orientation varies as to ward and clinical specialty; it differs also as to whether the location of equipment is identical or variable in all wards, and with the quantity of variable or new equipment and procedures.

The purpose of the conference is to introduce the new student to the physical set-up, to the ward plan of work, to the special routines, technics, and procedures, so that she may begin to give nursing care in a way which is satisfying to herself and to the head nurse. The first day on a new ward may be anticipated with delight or distress. This is determined and conditioned by the head nurse's personality as a teacher and as a person, her plan of work, her provision for time and for orientation, and her interest in students.

The first orientation conference should occur on the first morning in the division. Only those students who have just arrived should be included. This may mean that on several days in the course of a week the head nurse is required to spend an hour or longer in orientation. *This is a teaching responsibility* and can be decreased by providing for changes on but one day of the week. The orientation will differ then according to age groups. In the end, however, orientation is time-saving.

In selecting the material for the orientation conference, the head nurse may best consider which content can be demonstrated, which may be referred to for later reading and study, and which must be discussed with the student. Repetition should be avoided. The material presented should be pertinent to the particular ward and significant educationally. It should be more than the fetishes of the head nurse. She should keep in mind that comparisons are odious and negativism inhibits student interest.

*Example of Head Nurse's Outline for Introduction of a New Nurse
to a Private Surgical Floor*

This is a general plan which may be modified in relation to the previous experience of the nurse in the particular hospital and in consideration of the similarity of the various floor plans and location of equipment.

1. Have the new nurse attend the morning report at 6:55 A.M.
2. Introduce new nurse to the staff nurses and students, assistant head nurse taking charge until head nurse is free.
3. Tour the floor explaining the location of the following equipment:
 - a. Linen and small pillows
 - b. Utility-room equipment
 - c. Treatment room, sterile supplies, and dressing carriage
 - d. Medicines, thermometer and hypodermic trays, narcotics
 - e. Kitchen and fruit closets
 - f. Various ward keys
 - g. Appliances
 - h. Fire equipment and regulations
 - i. Ward library and bibliography
4. Explain the numbering or lettering of rooms, the naming of floors, and an unoccupied room, if possible, with its standard equipment, the signal system.
5. Show the location of the:
 - a. Doctors' order book; narcotic sheet
 - b. Kardex or nurses' treatment sheet for nursing orders
 - c. Assignment sheet
 - d. Patients' records
 - e. Diagnosis board, diet board, and similar sources of information
 - f. Administrative routines and nursing procedure book
6. Patients:
 - a. Diagnosis of patients with whom new nurse will have contact
 - b. Brief history of assigned patients
 - c. Patients' orders on Kardex or nurses' order sheet
 - d. Suggested plan for morning care of the assigned patients
 - e. After conference introduce to assigned patients
7. Explain a day's routine on the ward:
 - a. Usual succession of events: time for trays, baths, doctors' visits, nourishments, out-patient clinics, bed-pans, visiting hour, rest hour, afternoon care, evening care
8. Explain various types of workers on the ward; their functions and names:
 - a. Personnel under nursing department
 1. Staff nurses
 2. Ward helpers and ward maids

3. Orderlies
4. Secretaries
5. Red Cross aids or volunteer workers
- b. Other personnel
 1. Dietitians. (Explain nourishment sheet and permitted between-meal refreshments)
 2. Medical social workers
 3. Occupational therapist
 4. Physical therapist
 5. Laboratory technicians
9. Explain special duties—usual location of list of duties.
10. Give variation in procedure for admitting and discharging patients and giving medicines.
11. Show set-up and functioning of suction apparatus in use at present.
12. Outline ward-teaching program for the division. Discuss special procedures and case experience which student should obtain while on private floor.

SUMMARY

The greatest factors retarding improvement in conferences are traditionalism, fear, habit, and lack of knowledge of method and content. Some nurses still dislike to have their ideas challenged and find difficulty in being good discussion group members. A conference should begin with problems rather than pronouncements. Methods of conducting group conferences have not been completely satisfactory in the past. The future indeed offers a great challenge.

“A new and more dynamic type of teaching is necessary. Regardless of the different interpretations, it is a revolt against the more passive learning from books which has characterized so much of our schoolwork in the past. . . . It emphasizes the importance of interest not only in the work at hand but interest in improvement, an active, inquiring problem attitude, and the acceptance of the work as significant to the worker’s wants. . . .” *

* From Strayer-Frasier-Armentrout: *Principles of Teaching*, copyright. Used by permission of American Book Company, publishers, 1936, p. 170.

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8

The Individual Conference

AN OPPORTUNITY FOR GUIDANCE

THE INDIVIDUAL conference between the head nurse, assistant head nurse, or supervisor and the student nurse affords an exceptional opportunity for guidance. In fact, the aim of the individual conference is guidance. The conference period or interview affords the interviewer an opportunity to understand the student better, that is, to learn from the student what nursing experience she has had on a particular service, her interests in the present kind of clinical nursing practice, her finer lines of interest in nursing, and her special abilities and weaknesses. Guidance is built on a knowledge of both strengths and weaknesses, taken in fair balance. Hence we should anticipate that the graduate nurse approaches the conference with an unrestrained, unbiased open-mindedness. To obtain the maximum value from the conference, the student should meet the appointment in a similar frame of mind, though a certain degree of tension is difficult to avoid. However, this may be avoided through the ease and eager interest of the older nurse.

The individual conference is a teaching period. If correctly handled, it should have more learning values than a group conference as it emphasizes material the student has not already assimilated and does not waste time on known materials. It should be so planned as to time and materials that the positive learning values are provided for. The head nurse cannot ensure the desired outcome but she may, through thoughtful planning, obtain a high percentage of successful results. This should be based on a knowledge and application of interview technics. Several references in which these technics are presented in detail, are suggested at the end of the chapter.

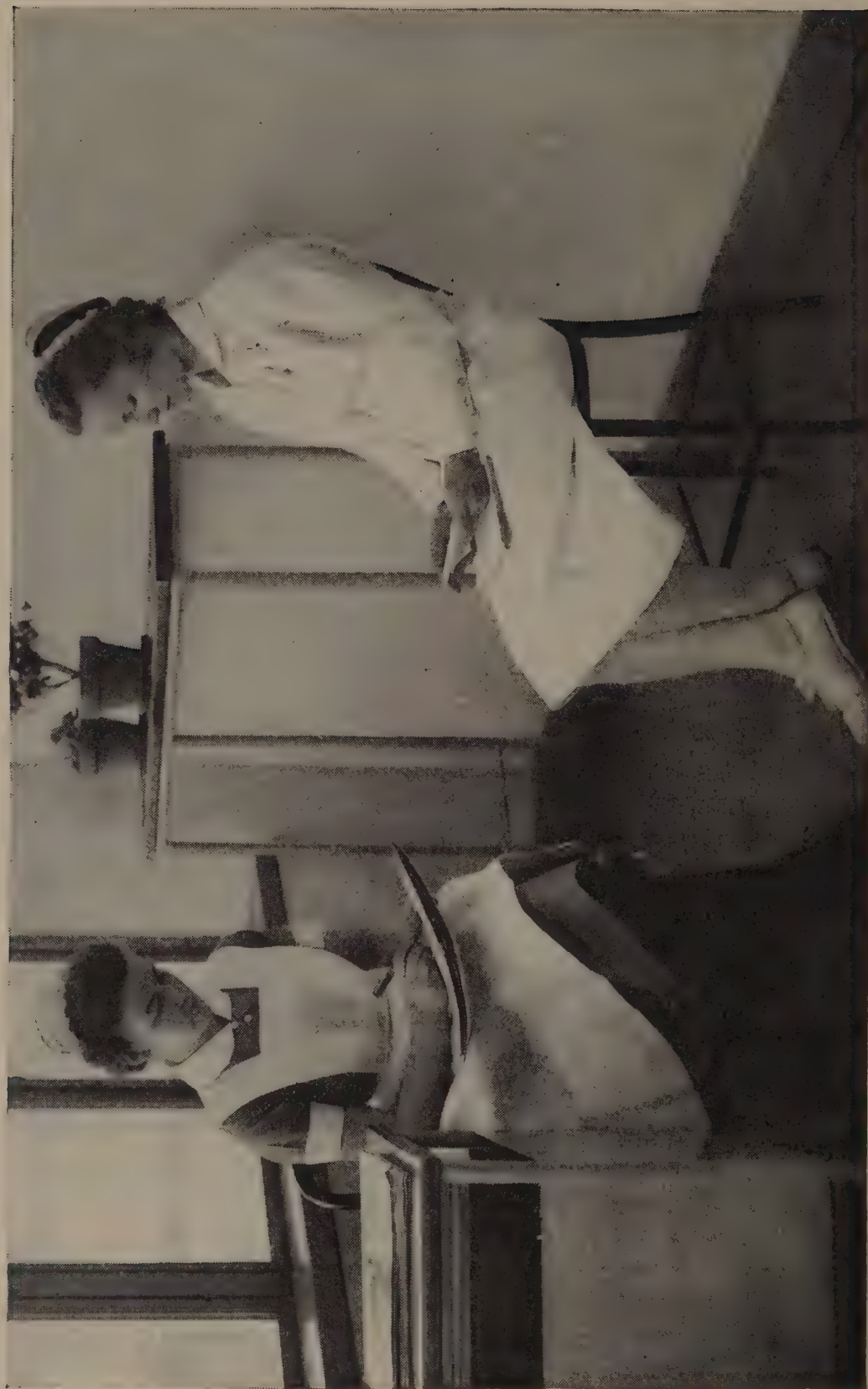


FIG. 7. The individual conference. The head nurse assists the student in enlarging her plan for nursing care of an acutely ill patient.

PURPOSES OF THE INDIVIDUAL CONFERENCE

In ward teaching, the individual conference is used commonly regarding the nursing-care study, the need for improvement in nursing care, and the ward or so-called "efficiency" report.

The conference regarding the nursing-care study should be arranged at periodic intervals during the course of fact-finding and preparation of materials. The first conference is to determine the best patient for a complete care study, the second is to determine the breadth of materials and study before the student begins to write or early in the writing period. The third is held when the corrected study is returned to ensure that the student interprets the instructor's evaluation correctly. If she so desires, she then has an opportunity to extend her study further in regard to certain aspects of care. During the period of preparation, the head nurse may suggest that the student consult a public health nurse, a social worker, or a dietitian regarding certain aspects of the study. This gives the student a feeling of research, that is, it provides opportunity for her to seek further information and possible solutions. It means also that contact with specialists is not on a forced level. Appointments for conference with special workers are made through the head nurse on a special slip, referred to as the "Appointment Notice." This is a small mimeographed slip, 4 x 5½ inches in size. (See page 114.) The purpose of this conference is clear—that is, to guide the student in understanding and recording the many aspects of nursing care which need to be considered regarding one patient with a particular condition.

A second major use of the individual conference is to effect improvement in the nursing care which the student administers. Here, understanding, consideration, and tact are far more beneficial than quick remarks, negative criticisms, and warnings. The head nurse needs to learn *why* the student is doing nursing procedures in an unsatisfactory way, and discuss the "why" with the student. The reason is more important than the isolated, inadequate procedure which, if pointed up, may loom as a hazard and block in the mind of the student. It is well to keep in mind that the nursing procedures which one most enjoys doing are those with which no unpleasant associations have been set up. Certainly, errors and omissions cannot be ignored, but the emphasis must be placed on the "why" and not on the procedure as such if satisfactory perform-

Appointment Notice

To:

From:

Conference with:

Re:

Date:

Time:

Place:

Comments:

ance is anticipated in the future. The "why" may be poor or inadequate comprehension of a particular technic, lack of insight into the patient's needs, false conclusions, or lack of interest.

The head nurse or supervisor must be careful to keep the purpose of the interview, i.e., to improve nursing care clearly in front of

the student. Side issues and unnecessary explanations should be avoided. Additional words give the head nurse the appearance of defending herself and, in addition, are extremely annoying to the sensitive student. Moreover, the student does not wish to hear about the similar experiences of the head nurse, hence she should avoid talking about herself. The head nurse's concern is regarding the student; the student need not be concerned regarding the head nurse and her problems.

Conferences relative to administering nursing care at night are both interesting and helpful. The student may be given guidance in planning the care of a larger number of patients and in planning time for the completion of administrative responsibilities. The emphasis in this conference is upon the planning of time, the recognition of the more important responsibilities, and the application of such administrative regulations as ensure the optimum care of the patients.

The conferences relative to the ward report should be at least two in number, the first occurring when the student has been on the division for just two weeks and the second at the termination of the experience in the division. These are held by the head nurse or supervisor with the student. At the end of two weeks, the head nurse marks the ward "efficiency" report in pencil. This represents her best evaluation of the student's work during the first two weeks on the division. (For a further explanation of the ward report, see page 270.) She discusses this pencil-marked copy with the student, bringing out strengths and weaknesses, places where improvement needs to be effected, and specific suggestions regarding adaptation to the particular clinical service. Two, four, or six weeks later, according to the system adopted, the head nurse marks the final ward report. In the interim, she has kept a running record of specific examples of good, average, or poor nursing care with the names of the specific patients and dates on which such care was given. Poor, excellent, and average characteristics are illustrated with specific examples. These are instances which have occurred frequently, are not isolated, and which represent the typical quality of the work. The student understands the purpose and sees the honesty in the selected examples or anecdotes. It is clear that this is a valuable conference, for it sends the student toward her new assignment with definite suggestions for improvement. And what student, at some hour in her nursing career does not aim to be the

"perfect nurse"? The head nurse and supervisor must catch and project these leanings toward perfection. Good guidance applies this.

CONFERENCE GROUPINGS

The possible conference relationships or groupings which may be set up are between the student and head nurse or between the student and supervisor. The ward supervisor may assume a percentage of the conferences regarding the nursing-care studies, regarding the ward reports, and, with the night nurses, regarding ward administration. The supervisor should not plan to see only those students whom the head nurse has difficulty in handling, or to see students only after the head nurse has had her interview. She should plan for a certain number of individual conferences and the student should feel free to approach her directly at any time. This attitude of interest in seeing students may be promoted by posting regular office hours and by creating the impression that students are welcome at this period with or without appointment. She should not be too busy to see students, for assisting students is an important responsibility of the teaching supervisor. Better nursing care is effected through student growth.

The young supervisor may experience some uncertainty regarding the interview technic. As this method is used to optimum advantage and so skillfully by social workers, it is suggested that the supervisor discuss the use of this method with her social worker, if one is available. She may be interested in giving several hours on the interview technic to the nursing faculty.

THE INTERVIEW TECHNIC IN THE INDIVIDUAL CONFERENCE

The following material is given in the hope that it will offer specific suggestions to the head nurse and supervisor on the desirable use of the interview technic.

The head nurse discovers the *why* of the student's difficulty. For example, the student:

1. May have some preconceived prejudice against a certain technic.
2. May have failed through carelessness or the urge to hurry.
3. May be slow in a particular area.

The head nurse may rehearse certain vital ideas for the student

who has no particular difficulties. If the student has no apparent difficulties, the head nurse would do well not to look for them. They may develop in another conference at which time she may assist the student without giving the impression of being overcritical. It is useful to check on the general trend of the interviews to determine where there are pitfalls for even the best students. A rapid survey of these points may reveal certain places where the students need aid. For example, in the nursing content for a particular clinical service, certain data or essential information needs to be rehearsed and expanded.

The head nurse may extend the instruction in major areas by referring the student to new sources of information. She does this by suggesting the reading of a particular chapter, by opening a text to pertinent information and, after giving the student a few minutes to read the data, discussing it with her. She is guiding the student, showing her new sources rather than repeating already familiar information, and helping the student save face. The process of referring to authorities in a particular field identifies the student with leaders in special areas of information.

The head nurse may renew the student's enthusiasm by increasing her intellectual interest in the material she is studying. This may have been dulled by routine assignments or by the feeling that she has been merely carrying out orders without identifying herself with them. By coming to the conference as a thinking individual rather than as an agent assigned to carry out orders, her position in her own mind is strengthened and she becomes a more important member of the group.

ESSENTIALS IN THE CONFERENCE TECHNIC

A summary of the essentials in the conference technic may help to show how a satisfactory interview can be achieved.

1. Mutual respect for the opinion and ability of the other person.
2. Common interest in the furthering of information.
3. Knowledge of issues to be covered. Both should make some preparation for the interview.
4. Issues and information should be of some significance. This gives the student a feeling that the head nurse has aided her.
5. Information should be given on a factual basis. Illustrations should not be personal as "Miss Jones is always making that mistake," or "Why don't you watch how Miss Smith does

that," referring to another student. The scientific approach avoids unfortunate and incorrect attitudes towards fellow workers and makes the student feel that she can safely ask questions.

6. Maximum use of time. The head nurse could to advantage understand the best learning periods of the conference. For example, in a thirty-minute period, the division would usually be as follows:

1-5 minutes. Establishing the tone of the conference and the main issues to be covered.

6-20 minutes. Covering the main issues. It is here that the main value of the conference lies, for there is the maximum interaction between the two members.

21-27 minutes. Enlarging upon the student's problems and giving some general advice. There is a definite let down in the tension.

28-30 minutes. Concluding the conference on a friendly tone and preparing for future meetings.

A following of this time allotment will ensure that the head nurse is not trying to give instructions when the student has not yet organized her thoughts or after she feels that she has learned what she wanted to know.

7. The head nurse should not plan conferences when she is already rushed or when she has many other problems on her mind. Since this conference relies on the attitude and the tone of the head nurse, she should plan to meet it in a balanced, sympathetic state of mind.
8. Selection of a location which permits ease in talking. It is a mistake to put a student in an uncomfortable chair or in a position which is inferior. If possible, the head nurse should not be disturbed during the conference. There should be the feeling that this is the student's time.
9. Questions may be used to direct the student to the solution of her problem. However a series of questions aiming at one solution may destroy her confidence in her own knowledge.

VALUES TO THE STUDENT

The head nurse should keep in mind the advantages which the student derives from the conference. Needless to say, these are in proportion to the head nurse's skill in conducting the interview, the

frequency of the conferences, and the general educational tone of the school.

The student desires a conference to find a solution for her problems or to obtain help in finding her own solution. If the student is familiar with the conference-teaching method, she can almost be relied upon to plan her own conference questions. The conference is not in terms of what the head nurse wants to accomplish but in terms of what the student actually needs. These cannot always be anticipated and usually are not identical. If the collective records of the group reveal certain deficiencies, the head nurse should direct attention to these points. For example, if difficulty is observed in the use of precaution technic, the head nurse may question the student about the underlying principles and the salient points in carrying out a satisfactory technic. The head nurse should remember that on the whole the student will reveal her difficulties by the questions she asks.

In making an appointment for a conference, the student assumes the responsibility for remedying her own deficiencies. If it is the responsibility of the student to outline the conference ahead of time, she will clarify her thinking and realize the need of the help she seeks.

The student has opportunity to ask questions which she would not take time to ask ordinarily because of the pressure of nursing service. As this is her time, she feels free to pursue the answers to questions in conference.

The head nurse and student establish a mutual basis for respect. Their meeting is on a discussion basis in which there is an interaction which cannot always exist on the ward.

The student gains a grasp of the finer details of nursing procedures and care. The feeling of mastery gives her a greater pleasure in carrying out the various plans of nursing care which she sets up. Checking on lecture information through this more practical agency—the individual conference—gives the student confidence in her ability to render more individualized nursing care.

RECORDING OF INFORMATION

The recording of the information obtained in the interview presents several problems. First, should the information be noted during or following the interview? It is far more satisfactory to record data following the interview. The reasons for this are evident; the

student feels more at ease to talk, she does not obtain the impression that what she says is to be a matter of record, and *rapport* is less apt to be broken.

Secondly, in what form should the data be recorded? The use of cards which can be indexed alphabetically and are easily available seems very adequate. In size, they may be 4 x 6 or 5 x 8 inches. Sheets of paper or miscellaneous notes may be lost or unfortunately mislaid, while cards kept in an appropriate indexed file or desk drawer are both accessible and convenient.

In recording data, actual facts should be listed separately from impressions. In analyzing data, facts should stand isolated as such. Information may be used according to the purpose of the interview, as a basis for the ward report or to provide a survey of the significant problems of the first- or second-year students in a clinical service. Significant information which needs to be stressed through ward teaching will be shown. By these indications, the head nurse may want to underline or star salient points on her teaching cards.

CRITERIA FOR A SATISFACTORY INTERVIEW

The major criteria for a satisfactory interview are: First, is the purpose accomplished? Has the instructor isolated the student's problems and answered them for her? Secondly, has the student grown through the interview experience? Has it added to her general feeling of well-being and her store of information? The degree of accomplishment is determined to an extent by the purpose of the conference.

According to Bingham and Moore,* "Success in interviewing is finally attained by discovering, mastering, and integrating the many specific habits, skills, and techniques required in order to formulate clearly the purpose of the particular interview, to plan its course intelligently, and to carry through its successive steps, from first approach to final write-up, expeditiously and well."

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9

The Nursing Clinic

DEFINITION

THE NURSING clinic is a type of group conference regarding the nursing implications and needs of one or two patients receiving care in the ward or division. At the nursing clinic the patient is either present or shown. The fact that the patient is seen during the teaching period is the differentiating point between a conference and a clinic. They are equally good methods and both have their specific uses. In some instances the patient cannot be shown. However, whenever possible, it is wise to present the patient. He is the major interest factor in the teaching period.

The patient may be presented at the beginning of the period, by bringing him to the teaching room or by taking the group to his bedside; he may be shown during the course of the teaching period, even to the extent of participating in the presentation of data; he may be shown at the end of the teaching period, or the group may adjourn to the bedside at the end of the more formal case presentation and discussion.

Often the patient may be placed at ease by being asked in advance if he is willing to come to the nurses' clinic on a particular day. The purpose of his coming is explained to him. If it is desired that he explain certain aspects of his history or his present symptoms to the group, he may do this to advantage by being advised of this request a day in advance. At a nursing clinic a patient may demonstrate how to test his urine, how to give insulin, how to prepare for and proceed with Buerger exercises, or how to apply hot fomentations with home equipment. If the patient can be given some small part or activity in the clinic, he may derive some little satisfaction from the effort he has expended to attend.

PURPOSES OF THE NURSING CLINIC

The purposes of the nursing clinic are:

1. To present a patient and his nursing problems to a group of students in order to help them to understand further the needs of the patient, the concurrent and future problems, and to set up some potential remedies.

2. To present a patient as a classical picture of a disease condition, with evident symptoms, and the usual methods of treatment. This assists the student in testing the accuracy of her observations and in interpreting the more formal course in Medical Nursing.

The purely nursing clinic, or the one which relates solely to nursing needs and problems, is presented usually by the supervisor, head nurse, or older student. The presentation of the case record with the medical interpretation of laboratory tests and studies is conducted by the doctor.

INSTRUCTION TO THE NURSE RELATIVE TO THE CLINIC

As the nursing clinic varies in emphasis, the head nurse or student giving the clinic should be informed by the supervisor in regard to the specific aspects to be stressed or emphasized. The amount of detail to be given and the problems for consideration should be agreed upon early in the preparation of the clinic.

The following outline has been used on an orthopedic ward with considerable success. The detail regarding the history is inclusive because in orthopedic conditions, particularly, the history is very significant.

A CLINIC ON AN ORTHOPEDIC PATIENT

Topics To Be Covered by Student Giving a Clinic on an Orthopedic Patient

1. History

a. Name, age, and occupation

b. Duration of condition

c. Description of orthopedic condition; use of x-rays if helpful

d. Previous treatment

(1) Conservative

(2) Operative

e. Recommendations for treatment at this time

(1) If conservative, why?

(2) If operative, what is to be done?

2. Nursing care

a. Mental aspects, difficulties of adjustment, etc.

b. Measures necessary for physical comfort of patient: arrangement of pillows, sandbags, and splints, turning of patient, etc.

c. Personal hygiene. How are patient and cast kept clean? Use of oil silk and adhesive. Does patient take proper care of teeth, nails, and hair, or are they neglected because of position of patient?

d. Bi-daily shaving of surgical area (preoperative preparation), purpose

e. Postoperative care, reason for orders given, other nursing measures effected in this particular case without written orders

f. Exercises taught and purposes

3. Health instruction; advice upon discharge

4. Social Service

a. Why is Social Service interested in this case?

b. How have they helped him financially or otherwise?

5. Follow-up care and prognosis

INSTRUCTIONS TO THE DOCTOR RELATIVE TO
THE CLINIC

The doctor is requested to present one or more ward patients. The topic should be adapted to the students' needs. The doctor should be informed of the nursing background of the students who will be present at the teaching. He is advised of the particular emphasis which the head nurse or supervisor feels is needed. He should be instructed specifically regarding the amount of detail about the disease condition, the length of time to give to the interpretation of laboratory findings, the needed interpretation of treatments, and the implications for nursing care.

The interne should understand that the clinic consists of planned material which is well organized. Doctors are interested in teaching student nurses, for they are their co-workers, and further learning, to them, implies more intelligent nursing care. The house officers or internes have a rich store of information from which to draw for nursing clinics. Furthermore, they are interested in case or patient

presentation. Many doctors truly like to teach. We should feel free to approach either a resident or a first-year interne who likes and is able to teach. Clinics are more easily planned when internes are available. Physicians may become interested, however, in presenting their patients.

The interne should be informed that the ward-teaching schedule is posted on Saturday for the coming week, hence he should notify the head nurse or supervisor by that day, if not agreed upon previously, of the patient whom he is presenting. The patient's name is placed on the schedule at least 48 hours in advance of the clinic, so that the nurses attending will have time to read the case record. He should be informed also that he must keep the appointment after the clinic is posted. Scheduling of early morning operations has been the greatest cause of omission.

Number of Clinics by Doctors. It is desirable to have one clinic given by a doctor each week. This is more possible perhaps on the medical, pediatric, neurologic, psychiatric, and urologic services. These may be scheduled satisfactorily at 7:15 A.M., 7:30 A.M., 7:40 A.M., and 8:00 A.M., the definite hour depending on the early morning work of the doctor and the nursing routine of the ward. A more difficult situation usually is presented on the surgical service, since the operative schedule begins very early and doctors' ward rounds and often dressings need to be completed before operations begin. If a regular clinic schedule cannot be maintained on the surgical service, intermittent clinics may be planned for afternoons. A clinic once a month is far better than none at all.

This problem of doctors' clinics may be attacked by requesting the chief physician of the surgical service to appoint an interne to give the weekly clinics. There seems to be no good reason why one interne cannot be given the responsibility for this part in ward teaching, just as one is given responsibility for the more formal lectures in the course in Surgical Diseases and Nursing.

VALUES OF NURSING CLINICS

It has been stated earlier that ward teaching should improve the nursing care of the individual patient. This is brought about in part by maintaining an active, eager interest in the patients at hand. How may interests be better augmented or learnings be fixed in the student's mind than by seeing the patient under discussion. Hence, with the patient in mind, we discuss, interpret, question,

seek to understand, and search for factors which may bring about a more satisfactory pattern of nursing care and a more adequate plan for convalescence.

EXAMPLES OF NURSING CLINICS

The possibilities of the nursing clinic are many. The following examples of clinics given during the past year may serve to demonstrate the true meaning and value of this teaching method.

1. A Nursing Clinic Given in a Medical Ward by the Head Nurse

PERIARTERITIS NODOSA

"I know you have been curious about this disease since the arrival of Mr. N. on the ward, so I have chosen it for the subject of our clinic this morning. Because it is a rare disease and not included in your general medical lectures, I shall briefly review it for you.

"First, what is periarteritis nodosa?

"First of all, it is a circulatory disease in which there is acute or subacute inflammation of the smaller and medium arteries. This may be due to a filtrable virus. It is characterized by the occurrence of sharply localized areas of exudation, degeneration, and proliferation in the walls (adventitial and mesial) of the arteries affected. These processes lead to the formation of well-defined nodes in the arteries and even aneurysms. You may have noted that I said 'may be due to filtrable virus'; the cause is unknown. It was thought that syphilis was the cause, but although it has been present in some few cases, in others, blood Wassermanns have been negative.

"The symptoms of this disease are variable. What do you think is the reason for this?"

Student: "Various arteries located in different parts of the body may be affected."

Head nurse: "The symptoms depend upon the location of the arteries involved. If there is involvement of the renal vessels we have nephritic symptoms; if gastric and mesenteric vessels, abdominal symptoms, such as severe abdominal pain, nausea, vomiting, anorexia, and diarrhea; if cardiac vessels, myocardial symptoms. The other constitutional and cardinal symptoms are fairly typical. The fever is irregular but rarely very high, while the pulse is very rapid in comparison. There is marked prostration, weakness, sweat-

ing, and progressive loss of weight. There is usually edema of the feet and ankles. Edema in face and body is possible but less common. The blood picture shows a marked anemia. Occasionally there is found asthma, cough and hemoptysis, or skin eruptions.

"The prognosis is poor. The disease terminates fatally, usually within a few weeks. The treatment, therefore, is symptomatic unless the patient has positive serology, whereupon the treatment is specific.

"If treatment is symptomatic, we have the clue on which to base all the nursing care. Briefly, this patient has been treated for sinusitis and post-nasal discharge with three operations within one year. He has also been admitted to the hospital previously for lung studies as well as for asthma. Upon discharge after the first admission he went to the country to rest and recuperate. He had been there but a day when he experienced pain in both lower legs, sharp and burning in character. Within one week the pain disappeared but reappeared in his left hand and at the same time he had numbness of both hands and feet. Next the pain radiated to the neck, left back, down to the left leg and foot. The leg could not be straightened. His appetite became poor. He had one attack of asthma four days before admission in March. After the last discharge, he also had a sore throat, from which he suffered for two weeks.

"The neurological examination showed poor movements in the wrists, fingers, and feet. There is better flexion than extension. The bicep and radial jerks were depressed; the ankle jerks were absent; only the right knee jerk was normal. Anesthesia was present on both hands and the right wrist up to and a little above the wrists. It was also present on the left leg above the knee and over the posterior thigh.

"Upon admission his temperature rose from 100° F. to 105° F. in two days; it slowly receded in the course of two weeks but continued to 'spike' intermittently on a low-grade basis during his remaining month in the hospital. His pulse and respirations were very high, 130-140 and 40-60 respectively during the period of high fever but receded with it except for a marked high pulse at the time when the temperature was 'spiking.' The pulse and respirations ranged between 96-100 and 25-30 respectively for over two weeks. The respirations finally were lowered when the patient's complicating pneumonia and lung abscess cleared. Why do you think he had pneumonia and abscess? What were contributing factors?"

Students: "He was susceptible to chest infections."

"He remained in one position in bed with the shoulders rounded and chest capacity decreased."

"He had lowered resistance following his respiratory infection."

Head nurse: "Yes, these were contributing factors. You may recall also that the patient's oral hygiene had been very much neglected."

"While here he had orthopedic consultations; casts were made for hands and feet to prevent wrist and foot drop. He also had nose and throat consultations regarding the post-nasal discharge; the treatment ordered was a menthol spray and oil to the nares. With improvement in fever, pulse, cough, and weakness, the patient was allowed to sit up and soon, when braces were made for the legs, he was taught to walk by use of the walker. He also was given occupational therapy. Soon he progressed to crutches and was finally discharged when he could walk with the aid of the braces and cane. His improvement was regarded as remarkable but nevertheless the prognosis was guarded."

"After five weeks at home, Mr. N. has come back to us again with abdominal pain as his main complaint. During his first week at home, he was able to get about with a cane; then he had a two weeks' period of asthmatic attacks, coughing up yellow sputum. The attacks passed away but he continued to feel worse, with anorexia, weight loss, and progressive weakness. Then his motor weakness and the loss of sensation in the right leg increased. Within one week of admission there was blurring of vision and the day before entry there was paresis and impairment of sensation in the left hand. He came to the hospital after a 12-hour period of upper abdominal pain which was knotty and fluctuating in severity. He had vomited three times since the onset of the pain. There had been no change in bowel movements. And so we have our patient brought to the date of this admission for consideration of nursing care."

"I have chosen this patient's case history to present to you and to discuss his nursing care, not because of the rarity of the disease or that it involves any unusual nursing care, but because this patient with his fatal disease serves as a challenge to your ability to give bedside care. There is nothing unusual about his treatment. It is purely symptomatic. I reviewed for you briefly his symptoms and treatments on previous admissions. Now I should like to discuss his care as we perform it every day."

"To begin with, Mr. N. is an individual who, because of his ill-

ness, has had a personality change from a happy, active, cheerful man to a sick, disabled, irritable patient. His mental attitude is one of discouragement. He sees himself wasting away. Each day he is besieged with a new or the same old pain. His hands and feet will not function properly. He can't get a good night's rest without medication. He sometimes is incontinent at night and also confused. All these factors added to long periods of hospitalization make him a patient who is requiring constant attention and who is critical of the manner in which a new nurse carries out his treatments. We can keep him happy by letting him have those nurses who are known to him care for him. As we nurse him we should keep in mind that Mr. N. has complained of headaches and has been known to have palpable nodules on his forehead. A cerebral process, in all probability, is believed to have started and therefore we must remember that the patient is not responsible for his irritability and must be treated passively. No nurse should allow herself to react to it emotionally.

"As you know, Mr. N. receives bi-daily warm nasal irrigations using a normal saline solution. Although he has had three nasal operations, his post-nasal discharge is quite severe and since receiving these irrigations his spells of coughing, clearing his throat, and even vomiting have been reduced remarkably so that he and the other patients are much happier. It was very distressing to listen to and must have been worse to experience.

"His appetite is poor and he can tolerate only soft, simple foods. When his tray is brought to him he has no desire for the food, but does attempt to eat. Therefore, the more attractive we try to make it, perhaps the more desirable it may become for him. The food usually starts him coughing, so if it is soft it is less dangerous.

"He has an order for five minims of adrenalin if an asthmatic attack occurs.

"Due to his coughing, post-nasal discharge, and asthma, Mr. N. requires good mouth cleansing, another requisite for stimulating the appetite. If his mouth feels clean he will feel more like eating. We brush his teeth five times a day and use a spray for his nose and throat.

"Mr. N. is extremely thin and very emaciated. The ordinary hair mattress was most uncomfortable in spite of the use of an air ring. Even the tufts seemed to penetrate the bed linen and make him aware of pressure. We now have secured an air-filled rubber mattress while waiting for the sponge-rubber mattress, and he is

much more comfortable. He receives frequent alcohol rubs to his back and lanolin is applied to the bony prominences and to his feet and hands, which are in casts. The latter are used only at night. A daily bath is necessary due to his profuse perspiration. We must support his arms well as he is too weak to pay much attention himself, particularly when he is napping. A footboard at the foot of the bed is an additional aid in preventing foot drop and keeping pressure from the toes. Mr. N. does not like to be fed but we see to it that his bed is adjusted and the food cut up. He receives an adequate diet supplemented by thiamin chloride to help improve his peripheral neuritis. His bowels are kept regular with mineral oil.

"And so here you have a man with a rare disease, sick, dependent on you. Your nursing care will make him comfortable and happy. It must be merely supportive care. It consists of ordinary hygienic measures, a good deal of cheerfulness, encouragement, and patience. This patience is most important for you and for the patient and I hope you will do your utmost to prevent this patient from becoming utterly discouraged and despondent. Perhaps in a few days when he feels better we can start occupational therapy again. He likes to weave and it may be good for his hands. At the same time physiotherapy may help him. What contributions have you to give which will afford us further insight into the care and needs of this patient?"

Student: "He is much more cheerful after his wife's visit. Could we suggest to his wife how much it seems to mean to him to have her come?"

Head nurse: "Yes, that is a good point, and as you are caring for Mr. N., you may have opportunity to speak to her yourself this evening."

Student: "I have found that he likes to rest twice during morning care, before he is turned for back care, and before the bed is made. Five minutes seems a sufficient period."

Student: "Shouldn't he be fed when he is so underweight and weak?"

Head nurse: "Feeding himself seems to give a feeling of independence which we should like to maintain. As this is a fatal condition, whatever makes him happy is important."

"Now you can see that upon approaching this man you need only to have confidence in your ability to cheer him. The fact that his disease is rare need not puzzle you. The main point is good supportive care with emphasis upon the psychological aspect."

"We shall now go to the bedside of Mr. N. and observe him for

a few minutes. Note his position, expression, response, emaciation, eyes, hands, and right leg. If you have further questions after seeing the patient, please come back to the teaching room and perhaps we can answer them."

NOTE: The head nurse and five students went to Mr. N.'s bedside. When the head nurse had asked the patient if he minded having all the nurses visit him next morning, he seemed pleased. As the group entered, the patient was resting. The conversation was as follows:

Head nurse: "Good morning, Mr. N., your nurse, Miss Jones, and I would like to point out to these other nurses the position in which you are most comfortable. Do you usually like the headrest quite so high?"

Patient: "When I've had a good night, I like the headrest high in the morning; when the night has been poor, I am more comfortable at an angle of 45 degrees less."

Head nurse: "You prefer to have only your hands, rather than the entire arm elevated."

Patient: "Yes, the feeling of numbness goes more quickly with my hands placed like this on small pillows."

Head nurse: "We should like to see the way in which your right leg is supported."

Patient: "I can't see it but it feels comfortable."

Head nurse: "Mr. N. has been having a little difficulty with his eyes. The blurring seems much less, though, than when he came back to us. Would you mind if the nurses felt one of the nodules on your forehead?"

NOTE: The patient acquiesced, the head nurse thanked him, and two nurses returned to the teaching room. The few questions asked were regarding the significance of the nodules, the extent of loss of sensation, and motor disability in the extremities.

2. A Nursing Clinic Given in a Medical Ward by a Senior Student Nurse

CORONARY OCCLUSION

"Mrs. C. is a 72-year-old woman who enters our hospital for the third time. Fourteen years ago, she first noticed the onset of her pain, which was located over her chest, shoulders, and radiated down her left arm. Twelve years ago she was told by her physician that her systolic blood pressure was about 220. The normal systolic blood pressure ranges between 110-130 mm. of mercury. Four

years ago there was an increased shortness of breath and she noticed that her legs became swollen more easily. This is due to the inability of the body to excrete the waste materials that accumulate in the extremities. Because the blood supply of the whole body is sluggish, these wastes are not picked up rapidly enough by the blood stream to be carried to the kidneys to be excreted.

"After a severe heart attack at home, she entered the hospital to see if there was some relief she could find for these symptoms. Upon her entry, the diagnosis, coronary occlusion, was made. Coronary occlusion is caused by a fragment of the blood vessel breaking off and leaving a roughened area on the interior of the blood vessel. Over a period of time, a blood clot forms over this area, shutting off the blood vessel and thus causing an area of the heart to be without blood supply. The blood vessels involved in this case are those which surround the heart muscle in the shape of a coronet, and are therefore called the coronary arteries.

"It is important to consider the familial history of all patients when they enter. Sometimes their present condition can be tied up with some of their ancestors'. Mrs. C.'s father was killed at the age of 35 in an automobile accident; her mother died at 73 of angina pectoris. This is another heart condition caused by a clamping down of the arteries, characterized by excruciating pain, and often due to physical or mental overexcitement and strain. Her brother died at 40 of congestion of the lungs. Excess fluid collects in the lung until there is no longer any room for air exchange and the patient dies. Its primary cause is heart failure. One sister died at the age of 27 from typhoid fever, and a second sister died at 29 of tuberculosis or pneumonia. There is a history of tuberculosis in one of her mother's sisters and in one of her sister's children.

"Heart patients often receive a drug called digitalis. It is used specifically in heart diseases because it acts on the heart muscles and helps the heart to do its work. On discharge, these patients may be instructed to call their doctor if they feel that the drug is over-affecting them; that is, if they feel nauseated or begin vomiting. They may even be taught to take their own pulses, and told not to take the drug if their pulse is 60 beats or below 60 beats per minute. However, in Mrs. C.'s case, it is felt best not to tell her any of this because she is the kind of person who will immediately experience these symptoms when she is not dependent on someone else's judgment.

"Mrs. C. was also x-rayed for gall-bladder disturbance, since she

had given some history of this trouble. Patients, especially over 40, who are inclined to be overweight often give a story of distress after eating fatty foods. The x-rays showed some gall-bladder disturbance, but because of the heart condition nothing was done.

"Mrs. C. lives alone in a furnished room on the second floor. She pays \$4.50 per week for her room. She receives \$34.60 a month from the Old Age Assistance, and \$4.00 from the Fields Memorial. As there is an elevator in the home, she does not have to climb stairs. An attempt was made after her first admission to have her go to a professional nursing home, but she refused. The social worker found that her home conditions were satisfactory enough, so that she would not have to go. A housekeeper comes in daily to help her with light housework. As she has all her meals in the dining room of the house, she does no cooking.

"On discharge, these patients are given instructions about diet, exercise, rest, and personal hygiene. As Mrs. C. is going home tomorrow, she has consented to come to the teaching room this morning, and have the discussion of her discharge instructions in your presence. She feels she knows all of us very well."

NOTE: The patient is brought into the room in a wheelchair.

Nurse: "Mrs. C., you have probably noticed that we have kept you in bed most of your stay in the hospital. When you go home we would like to have you rest as much as possible. A nap in the morning and afternoon, one after doing any exercise such as dressing, bathing, or walking will help you a great deal. The rest period should be 30 minutes in length.

"I understand that there is a housekeeper who comes in and does your housework for you. Is that right?"

Patient: "Yes, and when I go home now she is going to stay during the night too for about a week."

Nurse: "That's fine, then she will be able to help you get dressed in the mornings, won't she?"

Patient: "Yes, I guess she will."

Nurse: "There is an elevator in your home, isn't there?"

Patient: "Yes."

Nurse: "Then you won't be walking up and down stairs. It would be best for you to avoid doing such things as walking a great deal, lifting a chair, or bending over to pick something off the floor. How often do you take a bath?"

Patient: "Well, I don't take a real bath, but I have a sponge bath every day."

Nurse: "Do you sit down when you're taking it?"

Patient: "Yes, I sit on a chair right next to the wash bowl."

Nurse: "That's fine. If you stop and rest every once in a while you won't be so tired. Why don't you try resting your feet on a chair or on the rim of the bathtub when you are washing them, and then you won't have to bend over. Also, when you are drying yourself, if you pat yourself dry instead of rubbing, you will be less tired. Make sure that you dry yourself thoroughly because wet areas can become so easily chapped and then they will be quite uncomfortable. Do you like to use very hot water?"

Patient: "Yes, I like it quite hot."

Nurse: "That's one thing we should all be careful about. Sometimes we lose some of the sensitivity of our skin and do not realize how hot the water is, thus suffering a burn before we know it. How often do you like to wash your hair?"

Patient: "About every two weeks."

Nurse: "Do you do it yourself?"

Patient: "Yes, I have been."

Nurse: "How would you like to have your housekeeper do it for you? Do you think she would?"

Patient: "Yes, I guess she would."

Nurse: "I think she would be willing to help you, and when she does it for you, if you sit in a chair with your head over the back, you'll find it much easier. You are a Catholic, aren't you, Mrs. C.? Do you still go to church every Sunday since you have been sick?"

Patient: "No, I don't. The priest told me that it would be all right if I didn't go, and he comes up to give me communion every month. I only go to church once in a while."

Nurse: "I see. Do you think it would be all right for you to sit through the service when you go?"

Patient: "Yes, I do that anyway."

Nurse: "Now about your diet, Mrs. C. Do you like vegetables and fruits?"

Patient: "Oh, yes, I eat them all the time."

Nurse: "Fine, but you should avoid eating the ones that are hard to digest, such as cauliflower, peppers, radishes, cucumbers, and cabbage. Other foods such as ginger ale, soda pop, and apples will cause a lot of gas which may make you uncomfortable. You'll find that by eating small meals, and having crackers and milk between times, you'll feel a lot better. Do you like ham and pork?"

Patient: "Oh, yes, I like them a lot."

Nurse: "Haven't you found that after eating them you have some of your gall-bladder pain again?"

Patient: "Yes, I have, but I didn't think much about it."

Nurse: "You see, they are quite fatty and apt to start up your old gall-bladder trouble. Ham is quite salty too and will make you drink a lot of water. We'd like to have you limit yourself to one or one and one-half quarts of water a day. This will be fairly easy if you do not eat salty or spicy foods. If you only use salt for cooking and not for seasoning afterwards it would be better for you. How do you spend your free time?"

Patient: "I knit, sew, or read, and the lady next to me has a radio and we listen to it. She has a car too, and we go for a ride once in a while."

Nurse: "Then you find plenty to do, don't you? Do you go to the movies?"

Patient: "Not very often, only once in a while."

Nurse: "Have you ever been to the movies in the morning? If there is a picture you especially want to see, why don't you go then and in this way you will avoid the crowds. You know, you are more apt to catch cold when you are in a crowd, and we hope that you will be free from colds for a long time. Are there any questions you would like to ask, Mrs. C.?"

Patient: "Yes, only this. Can I have steak when I go home?"

Nurse: "You certainly can if it's well cooked and you chew it well and eat slowly. I'm sure you'll be all right if you follow these instructions."

"Thank you, Mrs. C., for coming to class this morning."

NOTE: Mrs. C. is wheeled out of the teaching room and the nurse summarizes the discharge instructions.

"You will note that I suggested when and how long the patient should rest. Most patients like Mrs. C. need specific instructions. As the housekeeper will be there each morning, she will not need to do any physical work. She will need to discipline herself, however, to save extra expenditure of effort. She is so accustomed to living an active life that curtailment will be difficult."

Student: "Why is it important that she doesn't lean forward?"

Nurse: "Leaning over with the head below the heart level frequently causes dizziness or may cause heart pain from sudden compression of the abdominal viscera against the diaphragm. A good rule for such a patient to follow is never to lean over forward."

"Are there other questions?"

Student: "Should Mrs. C. be advised always to use a footstool?"

Nurse: "Yes, when sitting in a chair. She has a carpet stool of her own and has a small wooden box which she plans to ask the housekeeper to cover for use when she visits her neighbor across the hall. She plans to keep this in her friend's room to save carrying it.

"Mrs. C. should live in moderate comfort for several years, if she observes these instructions. I believe she will, for she seems to appreciate their importance."

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10

Nursing Demonstration

USES OF THE NURSING DEMONSTRATION

THE MAJOR uses of the nursing demonstration in ward teaching are:

1. To show a method of doing a nursing procedure at the bedside of the patient or in a room adjacent to the ward.
2. To show how to teach the patient to do a procedure or treatment which he is to carry out after he goes home.
3. To give the special set-up and explanation of the use of equipment for an advanced nursing procedure.

The sight of an object or process gives a more correct and definite impression than the memory or discussion of it may afford. Objects and equipment unfamiliar or new to the students have still more value when used in an actual procedure. A colostomy bag or a pair of crutches as isolated articles have little meaning. When used in the care or treatment of a patient, they take on new meanings of usefulness and value.

ESSENTIALS OF A GOOD DEMONSTRATION

1. The equipment is accumulated, prepared, and tested in advance. This saves time and ensures that all equipment is in working order.
2. The instructor reviews the procedure whenever necessary, using the equipment, before she performs the demonstration for the students.
3. The demonstration is given on a patient who is in the division, if at all possible. If the patient selected receives this procedure as part of his daily care, interest is maintained.
4. The equipment is explained before the patient enters or the bedside is approached.

5. The procedure is done slowly or quickly, in consideration of the patient and the student learning, with as little discussion as possible in the presence of the patient. The emphasis at the bedside is on the steps in the procedure, with emphasis through vocal inflection or through repetition of the more important statements. In every instance complete statements rather than partial sentences are used.

6. A conference or discussion period, outside of the presence of the patient, should follow the demonstration. This affords opportunity for re-emphasis, for questions, and for summary.

7. If a patient is used, the patient should be asked in advance if he wishes to be the subject for demonstration. If at all possible, the procedure should be done at one of the regular treatment periods for this patient. That is, the patient should not need to feel that his routine is interrupted or an extra treatment is being done for teaching purposes. Following the demonstration, the instructor expresses her appreciation of the patient's kindness in acting as subject.

USE OF POSITIVE TERMS

In the nursing demonstration, the use of positive rather than negative terms in the presentation of content is of particular importance. Reference to and study of the expressions used by good teachers (see page 82) will be of value in correcting the poor habit of using negatives. In the demonstration, it is good teaching to place emphasis on *what to do* rather than *what not to do*.

In one demonstration, 30 minutes in length, of the nursing care of the pneumonia patient in the oxygen tent, the following negatives were used by a medical head nurse who is considered to have a wealth of information regarding nursing care:

"You don't want to give more than three ounces.

You don't want to force feedings on her.

Don't use a blanket two inches thick and very heavy; it's not the heaviness you want.

If you don't get results, try massage of the abdomen.

No point in trying to give an enema on the side.

We're not mentioning, etc.

You're not going to save the patient's energy.

That wouldn't be if the patient had, etc.

It wouldn't be up to you to go ahead and do it.

You don't need the canopy quite so high.

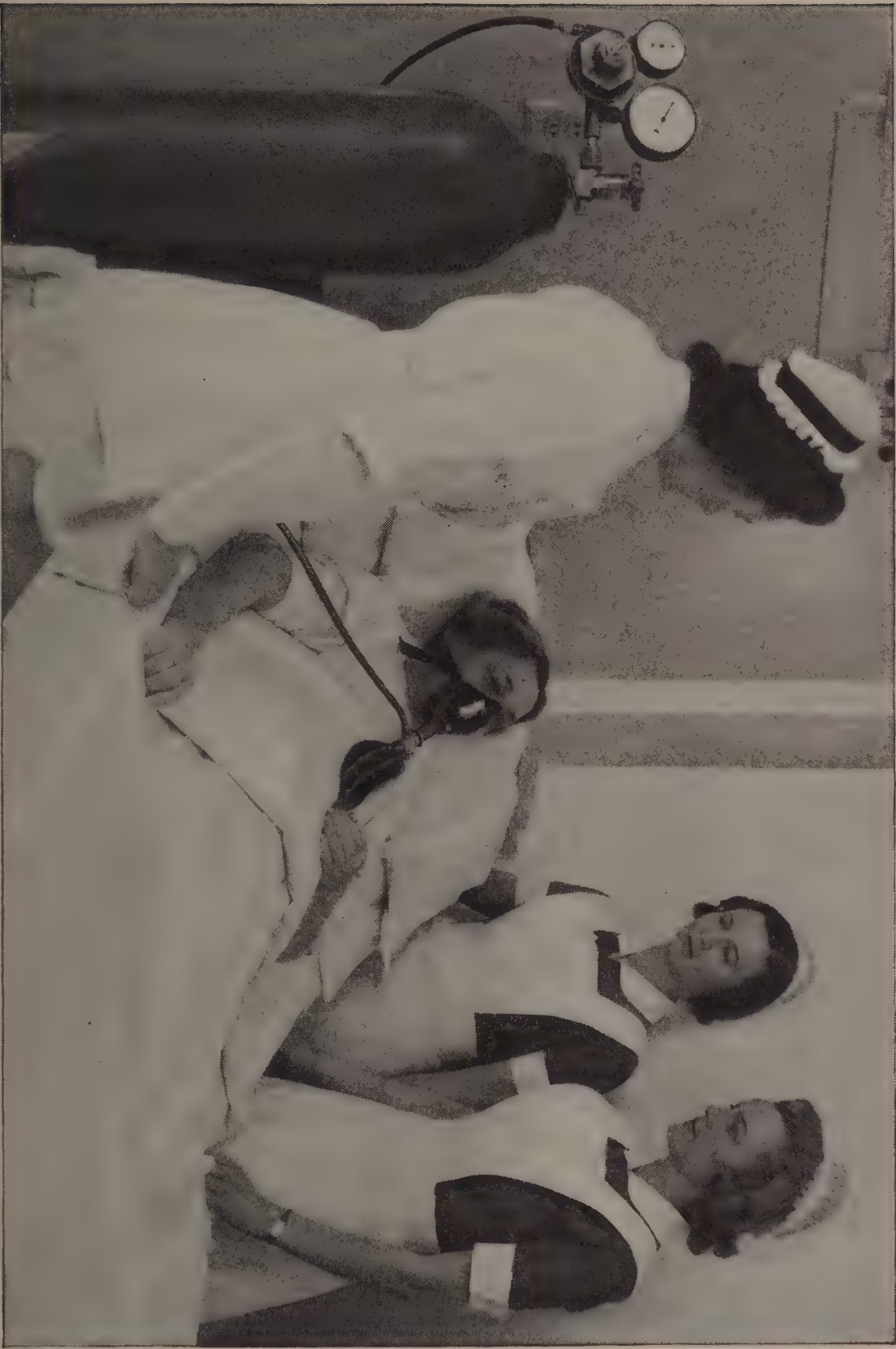


FIG. 8. Nursing demonstration. The head nurse explains the correct method of applying the B.I.B. mask. This demonstration is done most adequately at the bedside of the patient who needs an increased concentration of oxygen.

Just because *he doesn't* have one today, etc."

If the ward supervisor or second graduate nurse attending the teaching will make a list of the negatives used, attention will be called to it and the habit easily corrected.

EXAMPLES OF THE NURSING DEMONSTRATION

The following examples of the nursing demonstration may be suggestive. These outlines vary considerably in form and comparative content. As long as the instructor presents the essential content, the particular approach or technic may be considered a matter for choice. Each example represents a major use of the demonstration method as listed on page 137.

EXAMPLE I. TO SHOW A METHOD OF DOING A NURSING PROCEDURE AT THE BEDSIDE OF THE PATIENT OR IN A ROOM ADJACENT TO THE WARD.

To Show How to Turn a Patient in a Plaster Shell

I. "Neurologic Ward Problem Out of Which Teaching Arises.

Four days ago, Mr. H. was operated on for the removal of a ruptured intervertebral disk. His postoperative care requires frequent turning from back to abdomen in a plaster shell. As three new students have come to the ward this morning, and as two nurses are usually needed to turn the patient, the following demonstration is given by the staff nurse and third-year student in the teaching room adjacent to the ward. The patient is brought to the room at the beginning of the teaching period. Time—30 minutes.

II. Reasons for Turning Patient from Back to Abdomen.

- a. For change of position, which rests patient.
- b. To relieve pressure over body prominences.
- c. To promote good circulation and a healthy condition of the skin.
- d. To give back care, for bathing.
- e. To give back treatments and do spinal dressings.

III. Frequency of Turning.

Turn into anterior shell three times daily for periods of from one to three hours each. Suggested periods for this patient:

Two hours between breakfast and dinner.



FIG. 9. Demonstration of hand loom. The occupational therapist explains the use of the loom in an upside-down position to obtain exercise of special muscle groups. The student assists the patient in the correct use of this loom between the visits of the special worker.

Two hours after visiting hour and before supper.

One hour during evening or night.

Frequent turning every two or three hours has proved more satisfactory than a longer period of from six to eight hours.

IV. Procedure for Turning from Posterior to Anterior Shell.

If patient is small and comfortable in his shell, one nurse can turn patient unassisted. Two people are required to turn any postoperative patient, most men patients, and many others.

NOTE: The following steps are shown as the staff nurse describes them.

1. Have patient void before turning, using urinal in most instances. (This was taken care of before Mr. N. came to class.)
2. Protecting patient with small blanket, turn back top bedding to foot of bed.
3. Place two large straps wrong side up under posterior shell just below axilla and just above patient's knees. A third and fourth strap may be necessary if shells extend from lower legs to top of head. These are placed at neck and midcalf.
4. If dressing is to be done, unpin the binder and fold back the tails over the edge of posterior shell.
5. Smooth out nightgown over edges of posterior shell.
6. Place anterior shell on patient, adjusting it to fit the contours of his body.
7. Strap both shells together, bringing straps up tight and buckling them at the side where the shells join.
8. Both persons step to one side of bed. (Staff nurse and third-year student.)
9. Lift patient to side of bed toward you. Try not to drag patient, but lift him at chest and thighs. Work in unison.
10. One nurse (third-year student) remains at side of bed, steadying patient.
11. Second nurse goes to the opposite side and arranges the pillows and blankets onto which the patient will be rolled.
12. The number and arrangement of the pillows varies but in general they are arranged thus: (Folded or rolled large blankets may be substituted in part for pillows.)

For chest and upper abdomen: three large pillows, one placed lengthwise of bed, two cornerwise with the extra amount under the patient's abdomen.

For knees, lower legs, and feet: two large pillows placed in either of these two ways:

- a. One pillow crosswise under lower edge of cast and knees and the other used as a bolster for the ankle.
- b. One pillow placed lengthwise along each lower leg from knee down and the extra length rolled under at each ankle as a bolster.

For head: if no head piece on shell, one to three pillows as seems most comfortable for the patient.

13. Instruct patient to raise both arms over his head or place them closely at his sides. Tell him that he is going to be turned and to relax as much as possible. Mr. N. is familiar with this procedure, as you can see.
14. The nurse standing nearest the patient rolls him over onto the pillows; the second nurse supports the patient as he rolls over onto the pillows.
15. Unstrap the shells, removing the posterior one. Leave straps in place under the patient.
16. Lifting patient by the pillows, move him into the middle of the bed.
17. One nurse can finish the procedure.
18. Adjust pillows as necessary.
19. Give back and heel care to patient, rubbing well, to stimulate good circulation. Give special attention to bony prominences of the scapulae, sacrum, coccyx, and heels. Rub lightly in the thoracic and lumbar regions.
20. Tie patient's nightgown.
21. Pull up covers and leave patient comfortable. Place a shoulder or half blanket across his upper back and shoulders if necessary for extra warmth.

V. Procedure for Turning from Anterior to Posterior Shell.

NOTE: The following steps are shown as the staff nurse describes them.

1. Protecting patient with small blanket, turn back top bedding to foot of bed.
2. Untie all but top ties of nightgown and turn this back over sides of shell.
3. When dressing has been done, place binder in position and fold back tails over the edge of anterior shell.
4. Place posterior shell on patient's body.

5. Remove pillows from patient's head and legs.
6. Strap shells firmly together as described before.
7. One person stands at each side of bed. (Third-year student steps to further side of bed.)
8. Lift patient to one side, using chest pillows for lifting.
9. Have patient raise his arms up over head or place at his side. Tell him he is going to be turned. Mr. N. knows that we plan to turn him a second time.
10. Repeat the turning process as described in Steps 13 and 14 of previous procedure, except that you turn patient off of pillows onto the bed and remove the anterior shell.
11. Usually the patient needs to be lifted shell and all up in bed at this stage.
12. Drape patient with the shoulder or half blanket, putting it on lengthwise of his body.
13. Arrange pillows as comfortable; avoid arranging pillows in such a manner as to elevate any part of body which is in shell, out of position. You may note this usually by observing carefully the final arrangement.
 - a. The following arrangement usually is good for a regular knee-to-neck shell.

One large pillow placed just under upper edge of shell between shell and mattress, and extending up under patient's head.

One small pillow under patient's head and neck.

One pillow or folded blanket under each upper arm from edge of cast to elbow.

One pillow under knees with the knee rest on the bed slightly elevated.

No support is usually necessary for the feet or legs unless leg elevation is ordered operatively following removal of graft from tibia.
14. Rub the areas over the anterior superior spines of the ilia, patellae, and elbows with the rubbing alcohol, and dust with powder. Sometimes the patient's chin becomes irritated. This responds well to an application of witch hazel and zinc oxide ointment.
15. Cover the patient and remove half blanket used for draping and apply over chest and shoulders.
16. Elevate head of bed slightly."

NOTE: The staff nurse thanks the patient for acting as subject and requests the third-year student to take Mr. N. back to the ward.

VI. Discussion and Summary.

Student: "Why are there boards between the mattress and the springs?"

Staff nurse: "Short fracture boards under the mattress will prevent sagging of the patient and shell in the bed. These must be either full-length boards or a shorter length placed across center section of bed permitting elevation of gatch headpiece. Mr. N. has the shorter, cross boards."

Student: "Do most patients in body shells need footboards?"

Staff nurse: "Yes, in most instances. Because these patients are on their backs so much, and in bed for several weeks or months, special care must be taken to prevent foot drop. Footboards, covered with a sheet, may be placed upright between foot of bedstead and springs. Mr. N. likes the footboard, as it keeps the bed clothes completely above his feet."

Student: "Is it painful for the patient to be turned completely over?"

Staff nurse: "The shells are made before operation and fit the contours of the body, that is, support the body, quite completely. If the shells are strapped firmly together and the head and feet are supported so as to keep body in line, little pain will be experienced in turning."

Student: "Does the patient need to be turned exactly on time or may some leeway be permitted?"

Staff nurse: "This depends on the condition of the patient's skin and the routine for the particular day. Generally, a definite plan should be arranged and carried out. Change in position is an important aspect of care and when the nurse considers it an important procedure, the patient also observes it as such. If you anticipate an interruption in the schedule for turning, inform the patient in advance. When you are assigned to turn Mr. N. please ask an older nurse to assist you."

EXAMPLE II. TO SHOW HOW TO TEACH THE PATIENT TO DO A PROCEDURE OR TREATMENT WHICH HE IS TO CARRY OUT AFTER HE GOES HOME.

Walking with Crutches

I. Orthopedic Ward Problem from Which Teaching Arises.

In two days, Mr. B., who has had a fractured femur, is to be allowed to walk with the aid of crutches. The head nurse plans to have Miss J., a second-year student, instruct the patient in the type of walking which is indicated in this condition. As neither Miss J. nor Miss K. have had previous instruction in walking with crutches, the head nurse gives the following demonstration on the long porch adjacent to the ward. Three pairs of crutches have been obtained. Time—30 minutes.

II. Introduction (Head nurse).

“There are four usual ways to walk with crutches. The patient is taught the one best suited to his condition, that is, his deformity and general muscle balance. We aim to help him regain the use of the affected part as much as is permitted by the doctor. The nurse should, in each instance in which the patient is unfamiliar with the use of crutches, demonstrate how to use them to obtain rhythm. It is helpful to walk with the patient, using a second pair of crutches.

“Select a room with a smooth but unfinished floor. Waxed or varnished floors are a poor place for a beginner to learn. A floor which holds the crutch tip without danger of slipping gives a greater sense of security.

“In general, teach the patient to bear the greater part of his weight on his hands with elbows in full extension, and to use the axilla piece for slight weight-bearing and for balance of the crutch against the body.

“To protect any patient who is learning to use crutches, the nurse should grasp the patient’s clothing firmly between the shoulders. In case the patient slips forward or loses balance, the nurse could slip her hands quickly under the patient’s arms, saving him from falling.

“The nurse assists the patient to a standing position, allowing weight only on unaffected leg.”

III. Presentation of Four Methods of Walking with Crutches.

NOTE: The head nurse and student each take a pair of crutches.

The head nurse explains and demonstrates each method, then the students practice with the head nurse.

A. For a Person Who Is Not Allowed Any Weight on One of His Legs.

"The crutches are used together, putting a great deal of weight on the hands and arms. The arms are kept straight and the elbows stiff. The affected leg is carried slightly ahead of the body, in flexion if possible. (Head nurse flexes right leg at knee.)

"Standing on the good leg, reach forward with both crutches simultaneously, placing them about 12 inches to either side of feet, and swing body weight onto them. Swing forward onto good leg, keeping steps in as normal a range as possible, neither too long or too short and choppy, but simulating normal steps of the individual. (Head nurse takes two crutch steps and pauses. She directs the students to stand erect, flex the right leg. They take several crutch steps and pause.)

"Stress the rhythm of this walking by saying, 'crutches, good foot; crutches, good foot,' etc. When coming to a stop, the patient must stop on either weight-bearing point and come to rest by completing only a half step with the other member (i.e., crutches or good leg)."

(Head nurse says the above aloud as she walks down the porch. She asks the students to walk parallel with her, to learn the rhythm and length of the crutch step. Several minutes are given to practice, with attention to the method of coming to a rest point.)

B. For a Person Allowed Some Weight on the Affected Leg with Motion as the Essential Purpose.

"This same procedure is used when motion of walking on the affected part is desired, but when a small amount of weight is to be borne. This method is commonly used on patients with an internal derangement of the knee and for re-education of the hips following arthroplastic operations and fracture of the femur. This is the first method which Mr. B. will need to use.

"Use the good extremity as a complete weight bearer and for the second weight bearer use a combination of both crutches and affected leg, putting most of weight on the hands and forearms. Stress normal motion of both legs, using rhythmical steps. Also, saying, 'good leg, crutches—bad leg; good leg, crutches—bad leg,' etc."

(The head nurse stands in position, calling attention to the fact that although she is bearing most of the body weight on the left

leg, the right knee *is not* flexed. After taking four or five steps she begins to say the above. Then the students stand parallel to the head nurse and all three walk down the porch together. Next, the head nurse has each student walk alone, demonstrating methods A and B.)

Miss J.: "Shouldn't the under-arm part of the crutch be padded?"

Head nurse: "Whether or not the part of the crutch that fits under the axilla should be padded depends on the physician in charge of the patient. Often it is not padded unless the patient is obliged to put a great deal of weight upon it. A feeble or badly crippled patient, or one who has poor extensors of the elbow, that is, a weak triceps, might need such padding. This padding tends to encourage putting weight on the top of the crutch where it is poorly borne. This may result in very sore arms and in some instances in a brachial paralysis."

C. For a Person with Paralysis of the Lower Extremity, As a Means of Locomotion.

"This is called tripod walking because both legs together, swinging from the hips, act as one point of weight in the step and the crutches work together as the second part of the step. When the patient is in motion there are three points bearing weight almost at once."

(The head nurse outlines the triangle with crutch tip. She takes four or five steps, giving attention to the fact that the steps are moderate in length and taken slowly. She asks each student, in turn, to take a series of steps, insisting that they be taken slowly.)

Miss J.: "Aren't there four weight-bearing points? The feet are not actually together."

Head nurse: "In reality, the weight is on both feet for a few seconds while the crutches are put forward for the completion of a step or for starting a new one. The feet should be kept fairly close together. Caliper braces facilitate this.

"This type of walking is taught to patients who have paralysis of both lower extremities, such as old polio cases. The knees would be held rigid by caliper braces or in some instances by knee fusions.

"The length of the crutch step, i.e., from crutch to feet, may in some instances measure from four to five feet. For a patient learning to walk by this method, there is some danger of loss of balance on the forward swing of the body, resulting in the patient falling. The patient should be cautioned of this difficulty in balance. This may

be avoided in part by taking shorter crutch steps and by walking less rapidly. In teaching this method, it is particularly important to walk behind the patient and to have a firm grasp on his clothing."

D. *For a Patient Needing Aid in Balance and Some Assistance in Walking.*

"Explain to the patient that the doctor will allow as much motion and weight as can be tolerated, and that the purpose of the use of crutches is mostly for balance and possibly a little assistance. Little or no weight is borne on the crutch, as the patient endeavors to walk as normally as possible. This type of walking is greatly desired where full-range hip motion is to be encouraged. It is commonly used secondary to Types A and B. We shall teach this method to Mr. B. a little later.

"Direct the patient to step forward on one foot and the opposite crutch; complete step with other foot and opposite crutch. That is, left foot and right crutch together, and right foot and left crutch together. (Head nurse stands erect and takes several steps, saying, 'left foot—right crutch, right foot—left crutch,' etc. The students stand in position and with a 'left foot—right crutch,' step down the length of the porch.)

"As soon as the patient understands the motion, teach him to hold his body straight, to step forward rather than sideways, and so to prevent a swaying motion."

IV. Summary.

"These four types of walking with crutches you may see on the street and often in the hospital. Observe the correctness of their use and when possible observe why they are used. Tomorrow I shall expect you to demonstrate your ability to walk with crutches by these four methods. The extra crutches are kept in the supply closet and may be used for practice on the porch."

EXAMPLE III. TO GIVE THE SPECIAL SET-UP AND EXPLANATION OF THE USE OF EQUIPMENT FOR AN ADVANCED NURSING PROCEDURE.

Anthropometric Measurements and Weights

I. Aim.

1. By demonstration to show a method of measuring and weighing patients.
2. To give by actual observation a more lasting and vivid picture.
3. To show the importance of accuracy.

II. Subject matter (Time—25 minutes):**A. *Anthropometric measurements*****1. Definition:**

Anthropo—Greek root meaning “man, human being.”

Metric—Greek root meaning “measurement,” as in “metric system.”

The metric system of measuring a human being.

Involves measurement of standing height, sitting height, from symphysis pubis down to floor, and span.

2. Use:

a. In endocrine disorders before and after treatment.

(1) Pituitary gland.

Acromegaly—enlargement of extremities after 25 years of age.

Dwarfism—hypofunction of pituitary gland.

Gigantism—hyperfunction with enlargement of bones before 21 years of age, before epiphyseal fusion has taken place.

(2) Thyroid gland.

Cretinism.

Infantilism.

(3) Parathyroid gland.

Paget's disease—loss of stature due to bowing of bones.

(4) Osteoporosis—loss in stature due to collapsing of vertebrae.

3. Illustrations:

a. Actual photographs of above-mentioned diseases, in which patients are standing beside the measuring apparatus and compared with a normal individual of the same age.

b. Actual patient, Mrs. F., who has osteoporosis. There is an unusual porousness of the bones, usually affecting the vertebrae which collapse on each other and the person looks and actually is shorter. It occurs usually after the menopause, either artificial or natural. Mrs. F.'s was artificial, following an hysterectomy.

Dr. A. had the theory that since it occurred with menopause and usually affected women, estrone must play a part. He therefore noted that patients excreted a great

deal of calcium in the urine and stools. After giving them progynon B, one ampoule of 10,000 rat units intramuscularly every three days, the patients retained calcium and improved in every way.

Mrs. F.'s measurements before and after treatment with progynon B were:

Before Treatment	After Treatment *
1. Standing height ———	1.
2. Sitting height ———	2.
3. Symphysis down ———	3.
4. Span ———	4.

4. Consideration of patient:

Explain to patient what is being done to get the fullest extent of co-operation. This will also allay any fear the patient might have.

5. Procedure:

- a. Standing height. Have the patient stand erect on box, chin in and heels touching the back of board; have patient step aside and read the measurement. It is important that you read the height at the level of the eye, as you observe the meniscus of a medicine glass.

(Ask a nurse to read the height. She usually looks up to it, and this is incorrect. Write correct height on black-board.)

- b. Sitting height. Have the patient sit erect on box with hips touching back of board, feet flat on floor, chin in. It is important that chin is in, for any tilting makes the measurement incorrect. Read with the level of the eye. (Ask a student to read it. Write height on board.)

Which is larger, an inch or a centimeter?

- c. Symphysis down to floor. Where is the symphysis pubis? Locate it on the patient. (Head nurse locates this point with finger tips of right hand.)

Measure from this point to the floor in centimeters. (Head nurse measures and records distance.)

- d. Span. Have the patient sit erect on box, feet flat on floor, hips touching the board, and stretch arms out so

* Measurements were given in class but as this drug is still in the research stage, exact figures are withheld.

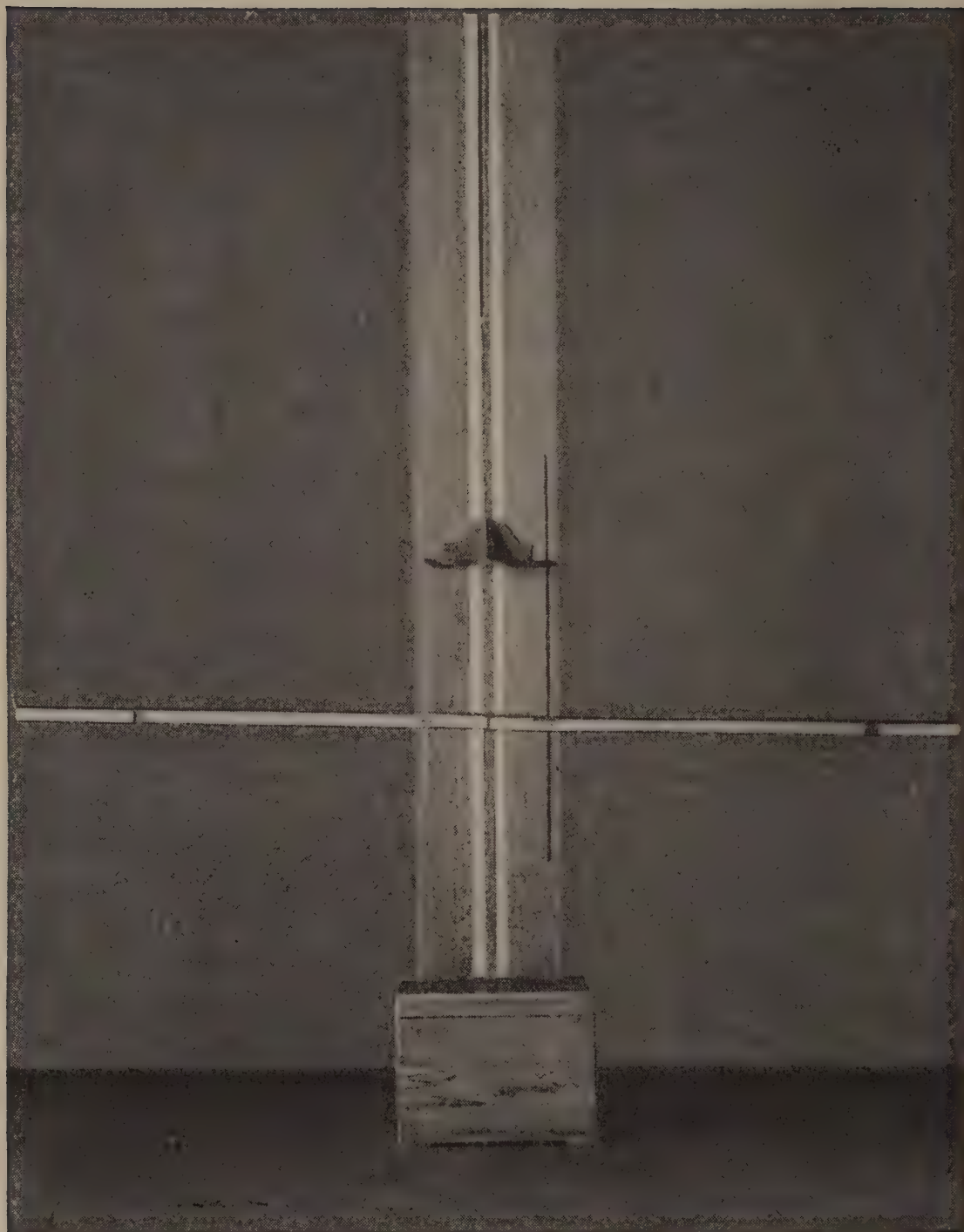


FIG. 10. Anthropometric measuring stand. This apparatus was shown and used in the demonstration. The triangular piece on the back of the stand may be raised or lowered along a metric measuring scale, to determine standing height, sitting height, and symphysis down to floor. The horizontal piece equipped with adjustable gadgets is used to determine span. The readings are made in centimeters.

that each finger tip touches vertical gadget. Tighten gadget and read as follows:

13.3 cm.

100

185.2 cm.

The center of the horizontal piece for measuring span is at 100 cm. The finger tips of each hand with arms outstretched touch 13.3 cm. and 185.2 cm., respectively. The span of the arms would then be the difference in the two measurements.

185.2 cm.

13.3 cm.

171.9 cm.

B. *Weights as done on Bulfinch 4*

Weights are important not only on a research ward but on all wards.

1. Use:

- a. Undernourishment.
- b. Overweight.
- c. Kidney disease.
- d. Liver disease.
- e. In metabolic study since any sudden change in weight, especially in patients on a constant diet, may mean too much medicine. In Addison's disease, a maintenance dose of desoxycorticosterone acetate is given according to weight; hence it is important that it be accurate.

To be accurate, conditions should be constant as to time, amount of clothing, an empty bladder, and previous to breakfast or eating.

2. Procedure:

- a. Heat scale with two hot-water bottles.
- b. Have patient void.
- c. Apply paper towels. Why are towels applied and changed between patients? (Have student participate.)
- d. Balance scales.
- e. Have patient stand on scales in a weighed bathrobe. Check pockets for excess weight, as cigarettes, curlers, handkerchief.
- f. Read weight carefully and seek explanation if there is too great a variation since last weight. This is especially true in:

- (1) Kidney disease—diuresis, edema.
- (2) Liver disease—abdominal paracentesis.
- (3) Obesity—low caloric diet.
- (4) Undernourishment—high caloric intake.

Mrs. F. weighs 50.10 kilograms. How many pounds in a kilogram?

- g. Table weighing. If patient is to be weighed on a table, balance table, blankets, and pillow, then weigh patient. If a discrepancy occurs, have a second person check your procedure of weighing. Subtract the weight of table and bathrobe from total weight to get the patient's weight. Record weight on special weight chart.

C. Conclusion

1. Measurements are important to the doctors and should be done accurately.
 - a. Remember that in measuring, the chin is in, the patient sits erect, the hips and heels are touching the back of the board, and the feet are flat on the floor.
 - b. Read at the level of the eye.
 - c. Become acquainted with anatomical sites used for measurements, as the symphysis pubis.
2. Review metric system of weights and measures.
3. In weighing patient, consider individual by:
 - a. Preventing infection.
 - b. Heating scales.
 - c. Explaining method used, especially in regard to weights.
 - d. Balancing scales carefully.
4. Weight charts are impressive both to patients and nurses, particularly for patients who are advised to gain or lose weight. They co-operate better if they can see the progress in a colorful chart. Example: Mrs. V. H.

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11

Nursing-Care Plan

DEFINITION

THE NURSING-CARE plan is the nurse's plan or outline for carrying out nursing procedures, treatments, and instruction for the individual patient. It takes into consideration his needs for rest and comfort, his preferences, and his limitations because of illness. This plan may be brief or detailed. Various forms have been published. It is an excellent method of individualizing nursing care. Essentially a plan would be useful in thinking through the care for every patient, but unless this is brief, it is obviously impossible.

REASON FOR THE PLAN

At intervals, a patient has been observed telling several nurses how to do his dressing, how to arrange his pillows, and how to make him comfortable. This frequent repetition was annoying to the patient. Some process was needed to save the patient from this trouble which was tiring to him and embarrassing to the nurse. In the case of the young student, she seemed unable to please the patients and frequently developed a lack of self-confidence.

A technic was needed for recording:

1. Personal preferences of the patient.
2. Procedure adaptations because of the disease condition or physical limitation.
3. Comfort measures needed between treatments, such as rest periods, medications, afternoon nourishment.
4. Supportive nursing care, that is, health and hygiene needs. This included such mental aspects as worries, fears, and things to avoid mentioning; and various other aspects, such as the care of calluses on the feet, preferences as to mouth wash, times when the

patient liked her teeth cleaned, the routine for the bath, powders, lotions, etc.

5. Patients' problems and how they were to be solved.

6. Teaching the patient discharge instructions, Buerger's exercises, baby bathing, or formula making.

OUTLINE FOR NURSING-CARE PLAN

The outline for the nursing-care plan and notes is given on page 157. Fundamentally, this has proved to be a good plan. However, because of the length, it is less often used than is desirable. It has been suggested that every nurse caring for patients keep one in use at all times. She might begin a new plan or continue to make notes on a plan which another nurse had begun. Such plans require time, and time must be provided if their use is to be effective.

The use of such an outline is considered fundamental in developing the concept of individualized nursing care.

The student makes notations on this mimeographed form which occupies both sides of a sheet of paper, 8½ x 11 inches.

ABSTRACTS FROM NURSING-CARE PLANS

The following phrases or sentences have been taken from nursing-care plans. In each example, the phrase was considered significant by the head nurse.

Supportive Nursing Care (II B).

"If time is given, patient will eat."

"Patient is on sponge-rubber mattress."

"Pull table down and against side of bed and patient will drink well."

"Small sips of water to quench thirst even though nauseated."

"Patient likes to read short stories; enters well into conversation."

"Occasionally needs encouragement regarding prognosis, but for the most part has a very good outlook on the outcome of operations."

Comfort measures (II C).

"Shades down at night; door closed with transom open."

"Likes to have back washed and rubbed with towel with up and down strokes rather than across as there is less pull on his legs."

MASSACHUSETTS GENERAL HOSPITAL
SCHOOL OF NURSING

NURSING-CARE PLAN AND NOTES

Name.....Ward.....Student's Name.....
Diagnosis.....Week of.....
Entrance Date.....
Home Address.....
Occupation.....Age.....Civil State.....Size of family.....
.....
.....

I. Prescribed Therapy and Remedial Nursing Measures:

II. General Nursing Care:

A. Of what does "routine" nursing care consist?

B. What additional supportive nursing measures are necessary for the care of skin, hair, mouth; nutrition and fluid intake; elimination; rest; exercise; good posture; diversion; satisfactory state of mind?

C. Comfort measures:

1. While nursing care is given. Procedure adaptations necessary in relation to disease; to personal preferences of patient.

2. During interval between treatments. Nursing measures and resources which secure relief from discomfort and pain.

III. Nursing Care Problems:

A. List them.

B. Plan for solving these problems. Notations regarding progress.

IV. Future Needs of Patient:

A. Is this a desirable period of illness to be helping patient make plans for the future? If not, give reasons.

B. What help will patient need in planning and managing his own care after hospitalization in regard to disease and treatment; health; social situation?

C. Did he seek or could you give any help for such care? Specify.

FIG. 11. Form for Nursing-Care Plan.

"Likes blankets between his feet and the support, as it is warmer."

"If you lower the head of the bed very slowly, there is less chance of his having muscle spasm."

"A urinal is used instead of a bed pan to prevent the pain which lifting brings on."

"Patient likes her own powder sprinkled on air rings and binder."

"Padding under legs must be pulled way over to inner side of splints to be comfortable."

"Prefers a medium headrest."

"Use cardiac table parallel to bedside with upper end of table even with head of bed. Enables patient to reach everything on table."

"No ice in drinking water."

"Needs padding on bed-pan because he is so thin."

"Folded blankets under each shoulder when in cast."

"Bobby likes pillows pulled way down on each side of his head and the bedclothes pulled way up and tucked under pillow."

"Likes to have his knees pulled up tight against his abdomen when he has gas pains."

"Patient detests stained linen."

"Exposed leg must be wrapped warmly at night."

"When patient asks for medication, do no mention its frequency."

Sections III and IV were often left blank. This was logical at first, for one nurse could not completely write out the plan until she had given care to the patient for several days. Problems may not be evident at first. When it was understood that the use of the plan was to extend over the entire period of stay, and that one nurse might well begin it and several nurses add comments to it as they successively gave care to the patient, the plan was used more satisfactorily. It was also found that the nursing problems (Section III) needed to be defined and interpreted. Frequently the nurses needed assistance in stating the problem. Examples of problems given are as follows:

"How to get the patient to put more heart into her exercises."

"To help the patient see the importance of weight gain."

"To decrease apprehension of patient."

"Getting the patient to drink fluids."

"Helping patient to become accustomed to the colostomy."

"Establishing the bowel movement habit."

"To keep the patient on bed rest."



FIG. 12. Future needs of the patient. The student assists the patient and mother in planning the convalescent routine at home. While the head nurse listens, the student nurse gives the instructions regarding the need for rest and the limitations in physical activity.

"Language difficulty. Patient does not speak English."

"Encouraging the patient to help herself as she is now strong enough."

"Encouraging patient to expectorate sputum."

"Helping the patient to want to get well."

"To teach the patient to walk correctly on crutches."

"To teach patient to maintain good posture while using the artificial leg correctly."

"Getting patient to lie on her side at night."

USEFULNESS OF THE PLAN

The plan is useful in giving the patient better nursing care. It is the most available tool we have for individualizing nursing care. As it provides a technic for knowing the patient's preferences, likes, dislikes, and needs, *it saves the patient from being the instructor*. It assists the nurse in noting the progress which the patient is making in his adjustment to present and future needs.

Nursing Care Plan as Part of Nursing-Care Study. The nursing-care plan is the logical antecedent of the nursing-care study. For several days the student keeps this plan for the care of the patient about whom she expects to make the study. She seeks out the nursing problems and considers the future needs of the patient. It is partly because of the insight gained through the care plan that she selects the particular patient for a detailed nursing-care study.

It will be noted that the outline of the nursing-care plan, page 157, makes up the major section in the outline of the nursing-care study, page 163. This is significant in that when the nursing-care plan is well done, a goodly section of the nursing-care study has been completed. This seems an excellent plan.

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12

Nursing-Care Study

DEFINITION

THE NURSING-CARE study is the thorough study and thoughtful understanding of "a patient, his problems and needs, and the nursing care which he received."* The constant emphasis must be upon the patient as a person—an individual, who has nursing needs during illness, convalescent needs within and outside the hospital, definite requirements for recovery and maintenance of health, and upon the method and thoughtful plan of the nurse for helping the patient to meet these needs.

Since the nurse is considering throughout the study the patient as an individual, she, with the standard pattern of care in mind, and a good background of factual knowledge about the disease condition, constantly considers, adjusts, and revises her care and instruction to meet the carefully calculated needs of the patient. Readjustment of the plan is essential as the patient's condition changes, and with it, his needs.

VALUES OF THE NURSING-CARE STUDY

The values of the nursing-care study are increasing with the more thoughtful use of this method. It affords the nurse a complete study of the many aspects of nursing regarding a patient for whom she is planning and giving care.

In this she tells how she gave care, how the patient reacted to her nursing care, how she adapted the procedures from day to day or from week to week to meet the special preferences and changing

* From: Taylor, Anna M.: Case Study or Nursing Care Study, American Journal of Nursing, 38:1010, Sept., 1938. By permission of the American Journal of Nursing.

needs of her patient. She presents thus the changing pattern of nursing care with reasons in a fairly common or typical disease condition.

Secondly, it affords insight into the complex reasons for illness and the many aspects to consider in planning for care and convalescence which will be fundamentally effective.

As well, the nursing-care study brings the broader study of clinical nursing, social needs, and community health and hygiene down to the specific implications in the instance of one patient for whom the nurse is responsible.

A major value also is the contribution which these studies afford to our nursing content. Certainly, many examples of procedure adaptations, individual technics, ways in which information was taught to the convalescent patient, who has a major disease condition, should provide variable gleanings for our store of nursing content.

ESSENTIAL CONTENT OF THE STUDY

The following outline of the general nursing-care study used throughout the school on the different clinical services, gives the major aspects for presentation and study. The first-year student is requested to place the Roman numeral in the left-hand margin of the study as each of the six sections is begun. This helps the student see the relative amount of content given under each major heading. Examples of the nursing-care study are given on pages 173, 182, 193, and 197.

The outline implies that the student is caring for the patient about whom she is writing. If this were not so, there would be little value in the study. She would be unable to obtain adequate content for the study, and all the major purposes would be defeated. That is, she would be unable to give better, more intelligent nursing care to this patient through the study. As she is able to plan more understanding care, she is thrilled by the potential insights looming before her, and hence led on to a constantly perfected pattern of care. All this is possible when the student begins the study with some little knowledge of the patient, and observes and cares for her for a period of two weeks while writing the study. Good content is possible only when paralleled by nursing care and observation.

Contrast this type of study with that written on a patient who has been discharged. The interest factor is constantly dwindling

MASSACHUSETTS GENERAL HOSPITAL
SCHOOL OF NURSING

OUTLINE FOR A NURSING-CARE STUDY

Student.....Unit Number.....
Year in School.....Diagnosis.....
Date.....Ward.....

I. The Patient as a Person:

Name (use initial), sex, age, religion, home, family, occupation, and approximate amount of income from it, personality, intelligence, education and special interests

II. The Effect of the Disease on the Patient:

Past and present
Symptoms shown
Signs shown
Significance of the foregoing

III. The Effect of the Treatments (Medical, Nursing, and Dietary) on the Patient:

Treatments: purpose, therapeutic effect
Other effects—physical, physiologic, psychological, emotional; their significance

IV. Nursing Care:

Variations in the “routine” nursing care
Supportive nursing care
Comfort measures:
Procedure adaptations in relation to physical limitations; to personal preferences of patient. Nursing measures and nursing resources to secure relief from discomfort and pain during interval between treatments

V. Nursing Problems Related to Patient’s Care:

Problems which arose; including feeding problems
Plan made for solving and success of plan

VI. Helping the Patient Plan to Meet His Future Needs:

Specific teaching relative to his condition, treatments, diet, hygiene, social situation. Consider preventive measures; occupational problems. Specific advice relative to resources for further help and use of community agencies.

VII. Sources of Reference:

Bibliography. All direct quotations should be accredited to the source from which obtained. Conferencès.

FIG. 13. Nursing-Care Study Outline.

and the patient does not profit from this extensive study by the nurse. Again, occasionally the question is asked if the student cannot write a study on a patient who has been taken by death. The interest factor is questionable and as well, the social aspects



FIG. 14. The dietary conference. The dietitian discusses the essentials in the high-vitamin, high-caloric diet with a young patient who is seriously underweight. The student listens in to learn the technic of approach and the teaching content.

can be studied only from an admission viewpoint. There would be no consideration of future needs or convalescent care. Such studies should be discouraged as they tend to stress the medical aspects of the case.

On the next page is given the outline of the Observation Study which is used in the Emergency Admitting Ward. The purpose is what the title implies, namely, observation.

MASSACHUSETTS GENERAL HOSPITAL
SCHOOL OF NURSING

OBSERVATION STUDY

Patient's Name.....Student's Name.....
Admission Diagnosis.....
Occupation.....
Entrance Date.....
Home Address.....
Age.....Civil State.....Size of Family.....

I. Appearance:

II. Signs and Symptoms:

III. Emergency Treatment:

IV. General Observations:

V. Prescribed Therapy and Remedial Nursing Measures:

VI. General Nursing Care:

A. Routine care

B. What additional supportive nursing measures are necessary for the care of skin, hair, mouth; nutrition and fluid intake; elimination; rest; exercise; good posture; diversion; satisfactory state of mind?

VII. Patient's reaction to care:

A. Steps taken to help patient adjust to the Emergency Ward.

VIII. Future needs of patient:

A. What help does patient need to avoid repetition of his present condition?

B. What help does he need in managing his condition at home?

IX. Instruction given, or instructions which you believe should have been given. Why was it omitted?

FIG. 15. Outline of Observation Study.

The student makes notations on this mimeographed form which occupies both sides of a sheet of paper, 8½ x 11 inches.

CONFERENCES RELATIVE TO THE STUDY

The number of conferences which the student may have while writing her study will vary from two to five. The number varies with the particular patient and the various workers who may give insight into the patient's needs.

The first conference is between the student and the head nurse for the purpose of agreeing on a patient for study. The student knows the patients which interest her most in the light of her experience in the school and her previous nursing-care studies. Variety should be observed as to disease condition, nursing problems, and future patient needs. The head nurse knows the approximate future period of stay of the patient and whether she will be able to permit the student to give care to this patient for a period of two weeks. This first conference is obligatory, but may be very brief.

The second conference with the head nurse usually is held on the fifth to the seventh day after the medical texts have been studied and the data organized. At this conference, the head nurse advises the student about the special conferences which may be of help to her, namely, with the resident or senior interne caring for the patient medically, with the social worker, if the patient is known to social service, and to the public health nurse on the staff if the future needs of the patient indicate the value of such a conference. The majority of the students will benefit from a conference with the public health nurse at which is discussed the preventive aspects and the individual and community health problems related to each patient. The supervisor shares with the head nurse the load of the second conference and follows the same student for the final conference regarding the evaluation of the study. Occasionally a conference with the dietitian is arranged if the dietary problems indicate the value of it.

The head nurse or supervisor approves and arranges for the conferences which the student requests. The appointment notice slip, which is shown on page 114, is given to the student to ensure correct data regarding the appointment. To the conference, the student brings her data regarding the study, pertinent questions, and the patient's record. These conferences vary in length from fifteen to thirty minutes.

The student lists the conferences which she has under sources of reference in Section VII.

EVALUATION OF THE NURSING-CARE STUDY

The nursing-care study should be read and evaluated first by the head nurse who knows the patient or by the teaching supervisor who may be completely responsible for the studies. This should take place within a period of three or four days after the student completes the study; otherwise, that is, if delay occurs in returning the study, the student loses interest in it and if a carbon copy has not been made, loses much of the detail which is basic to her improvement in nursing care. The student anticipates this criticism, and for the greatest value it should be prompt. Following the first evaluation, the head nurse may have an immediate conference with the student or, if some question arises in her mind, discuss the study with the supervisor. However, the supervisor reads all the studies which the head nurse evaluates and may discuss re-evaluation with the head nurse. She is able thus to assist the head nurse in arriving at a more accurate evaluation and in grading the study as against many studies of patients with a similar condition. The supervisor may assist her four or five head nurses in arriving at a similarity in the use of the evaluation technic.

The following outline of *Suggestions in Evaluation of a Nursing-Care Study* (pages 168 and 169) has been set up as a tool of evaluation. Under "B," it will be noted that each Roman numeral refers to a major section on the original care-study outline. The percentage values indicate the relative importance of the various sections. Admittedly, this is arbitrary, but some suggestion as to value is better than none at all.

To help the head nurses to determine the relative weight of the seven sections of the study, the *Grading Scale for the Nursing-Care Study* (see page 170) was set up. This slip is clipped to the front sheet of each study and weights for each section are determined. This slip is returned to the student so that she may see wherein her study was weak or strong. If time permits, it would be far better evaluation for each head nurse to determine the relative weights which each section of the particular study should carry. However, because of the pressure of time, lack of preparation and inexperience, this is too often impossible; so at present, this intermediate step is set up.

SUGGESTIONS IN EVALUATION OF A NURSING-CARE STUDY

A. CONSIDER THE STUDY AS A WHOLE:

1. *Purpose*: Is the purpose of this study made clear, namely, to present a patient for whom the student has cared and his nursing needs? Does this study make a contribution to our knowledge of nursing care?
2. *Point of view*: Are major statements logical, in good sequence, backed by factual data and thought-provoking? Has the student presented the point of view of a nurse, social worker, scientist, educator, economist, patient, or doctor? Is it integrated?
3. *Form, style, spelling, and grammar*: Are the sections arranged in logical order with adequate weight given to each? Is the style interesting or repetitive, intriguing or monotonous? Is it written in the student's own words? If the spelling is incorrect, what English or medical dictionary has the student used? Is it customary for the student to make such kinds of grammatical errors? Has the student made an effort to improve in grammar? If the organization and grammar are poor, does the purpose or content merit the time required for rewriting? Correct errors in spelling or grammar but do not subtract credit.

B. CONSIDER EACH SECTION OF THE STUDY:

I. *Patient as a Person* (10%)

Is the patient well pictured? Do you see him as a member of his community and family group?

II. *Effect of the Disease on the Patient* (10%)

Are the signs and symptoms differentiated clearly? Subjective and objective symptoms? Is there a comparison with the normal clinical picture? Are terms new to the student defined by use of a reference book? Are laboratory findings compared with the normal? Is the significance of the variations stated? Does the student give her explanation of certain facts of the case? Is there a good discussion of factual material?

III. *Effect of the Treatment on the Patient* (15%)

Is the effectiveness of treatment and nursing procedures described accurately? Does the patient understand the purpose and sequence of treatment given? Is relationship shown between treatment administered here and treatment to be continued after discharge? Has the student described the patient's physical and emotional reactions to treatments? (Richest observations are those of mental reac-

tions.) Is she interpreting his reactions with some consideration of and insight into his home demands and environment?

IV. *Nursing Care* (20%)

Is supportive nursing care considered significant? Is the nursing care adapted to this particular patient? Does the study give a full plan of the nursing care which the patient needs? Are there variances not commonly found? In consideration of the disease, is due emphasis given to the major points in nursing care? Does the student understand the complete nursing care for this type of patient? Has the student made an adequate plan for health teaching?

V. *Nursing Problems Related to Patient's Care* (20%)

Do problems so stated represent true problems? Has the student grasped the major problems in this case? Has she dealt with them understandingly? Is this plan a sound one? Is the degree of progress stated? Has a definitely social problem been referred to Social Service early enough for an effectual plan to be made?

VI. *Helping Patient Meet His Future Needs* (20%)

Has the student given the patient and family progressive, adequate instructions which will make his hospitalization effective and future more healthful? What plan was made? Has the patient provision for home care in regard to treatment, diet, and rest? Has the student utilized teaching situations on the ward which may be transferred into the home? Is the return appointment understood, and has he means of getting back to clinic? Is the effect of this disease upon the patient's family understood and clearly stated? Are the relationships between the social background and current problems made obvious? Does the student recognize the preventive medical and social aspects of the case? If this disease represents a public health problem, is this relationship and the incidence of the disease given? Is the interpretation of the social agency given?

VII. *Sources of Reference* (5%)

Has the student shown good judgment in the references which she has selected? Has honesty been observed in the use of other writers' materials? Are editions given? Have the most recent editions been used? Are statements taken from periodicals, theories or proved facts? Can you suggest references which would enlarge her knowledge or afford newer materials for the major part of the study (if this is necessary)?

Student:

Grading Scale for Nursing Care Study

1. Patient as a Person.	10%	
2. Effect of the Disease on the Patient	10%	
3. Effect of the Treatments on the Patient	15%	
4. Nursing Care	20%	
5. Nursing Problems Related to Patient's Care	20%	
6. Helping Patient Meet His Future Needs	20%	
7. Sources of Reference	5%	

FIG. 16. Grading Scale Slip.

Number of Studies Required. An arbitrary question frequently arising refers to the number of studies which should be required. Certainly the answer is no more than can be done well. Two or three well-written studies per year are better than many superficial outlines. Certainly, one medical study and one surgical study during the first year; one pediatric study and one obstetric study; and one for the special clinical services to which the student is assigned for a period of four weeks or longer. These might include the dermatologic, urologic, neurologic, psychiatric, and orthopedic services. In addition, the student should write one out-patient study during her experience in an out-patient clinic.

In the operating room and in the diet kitchen a different type of study is written. These are very highly modified nursing-care studies, with a completely different emphasis.

In the "Ward Instruction Record" used at the Massachusetts General Hospital, the data regarding the completed studies is listed. This includes the ward, the disease condition, the record number, the dates on which the study was begun and completed, the grade, the use of a nursing-care plan, and the supervisor's signature. This record (see page 172) should be kept up to date by the student and may prove helpful to the supervisor and head nurse in assisting the student in selecting a new patient for study and in spacing studies. Duplication in conditions is avoided.

Occasionally some question arises regarding studies on private patients. These are possible and very helpful in some instances. The plan might be for the supervisor in the private pavilion to

assist the student in selecting a patient for study if one has not been completed for both medical and surgical nursing on the general wards. Hence this special department serves as a check on the completion of studies for the two major clinical services. Studies are not routinely written on private patients as the case record is usually less complete or not available for reference.

SUPERVISOR'S RECORD OF NURSING-CARE STUDIES

How may the supervisor or head nurse keep an adequate record of the studies which have been assigned, written, or not completed for a specific reason? Two methods are suggested.

1. A mimeographed list of the students in each newly accepted class is given to each supervisor. She makes an index card (3 x 5) for each potential student to her service and places them at the rear of a file box. Each week when the ward changes are made, the supervisor receives a triplicate copy. She then moves the cards of her new students to the front of the file box. This is her active data regarding studies assigned, conferences, and completed studies. Notation about the efficiency or ward report also is made on this card.

2. The mimeographed list of the students in each newly accepted class is given to each supervisor. A copy of this list is issued for each special service for which she is responsible, on which studies might be written. One list is headed Orthopedics, while another may be marked Surgery. When the study for the service is completed, a line is drawn through the student's name. This is a simple way of checking each class in progression.

A second mimeographed sheet ($8\frac{1}{2} \times 11$) is used with this second method as a work sheet. Each student's name is listed according to the weekly changes. Opposite the name is listed the status of the student, the date when the study was assigned, and completed, the patient's unit number, the conferences held, comments regarding the disposal of the study, and the date on which the study was permanently recorded. The sheets for this method are kept in a loose-leaf notebook.

At present, a list of the nursing-care studies written by each student is placed on the back of the summary sheet for ward instruction (see page 18) which is placed in the permanent folder of each graduate of the school. The front side of the sheet contains the number of hours of ward instruction received by the student in

NURSING-CARE STUDIES

Service	Ward	Disease Conditions	Unit Number	Date Begun	Date Completed	Grade	N. Care Plan	Supervisor
Medical 1.								
2.								
Surgical 1.								
2.								
Dermatologic								
Orthopedic								
Urologic								
Pediatric								
Neurologic								
Psychiatric								
Private Patient								
Out-patient 1.								
2.								
3.								
Others								

FIG. 17. Form for Recording Nursing-Care Studies.

each clinical service and the total hours of ward instruction received during the three-year course.

FUTURE OF NURSING-CARE STUDIES

The nurse-instructor needs to have faith in the future development of nursing-care studies. They are one of our very finest methods of perceiving the needs of the individual patient, hence of individualizing nursing care. By constantly observing the students' studies, the supervisor may detect wherein improvement is needed, and it will always be possible to refine to a higher degree our insights into individual nursing needs.

EXAMPLES OF THE NURSING-CARE STUDY

Fracture of Femur and Arteriosclerosis

A Surgical Nursing-Care Study

By a First-Year Student

I. "Mrs. C. is seventy-five years old, a Protestant, of Irish parents, born here in Boston where she spent most of her life. Her mother was over seventy and paralyzed when she died; her father died at fifty of diarrhea. Mrs. C. has no siblings and has no knowledge of any family medical history. She married at eighteen and lost her husband twenty-five years ago. He died after two weeks in a hospital following a leg fracture. My patient had two pregnancies—one a miscarriage, and the other producing a daughter who 'soon died.' She says of herself that her 'urine has been slightly strong lately.' Also she has lost four pounds, but that otherwise she has always been well except for an occasional cold. As a child she had measles, but she has never been hospitalized before. Today she told me that she never went beyond high school, for she married young. At present, or rather until she tripped over I don't know what and fell and fractured her leg, she worked as a companion and domestic for a friend 'who would do anything for me and give me anything.' (She has just come back from three years in Europe.) She has three cousins, all school teachers; these are her only relatives.

When I first took care of Mrs. C., some weeks ago, she told me about a few of her friends. She spoke of the many that had died in the last few years and of the many that the years had taken away. I gathered she must have had a great many, and I can readily understand, for she has a cheerfulness and a bit of humor about

her that brings a smile when she comments tellingly on the events of her daily life. Little things, like enjoying the passing of people up and down the corridor and her simple but wholesome enjoyment of some pink paper napkins someone had given her, told me much of why she had so many friends. Warm-hearted, keen in her appreciation of what others did for her and acutely aware of the feelings of others were things I soon discovered were part of Mrs. C.'s make-up. She was quite Irish in this. I feel sure she was a good and faithful servant and a merry companion—(she was a companion for twenty-three years to the same people). Her position must have been similar to the old family retainers. She is that kind of a person. Her interests were those of the family, for one has the sense that she is selfless in her thoughts, always so willing to comply that one knows she has always done as others wished her to do through countless years. I know this, for she will say to me, 'It must be right if you say so.' I believe her education was much more practical than theoretical, sufficient and adequate for her job, and gleaned out of a lifetime of living."

II. "I doubt that Mrs. C. knew that she had arteriosclerosis, and the only indication she gives of any trouble is her telling phrase that the 'urine has been slightly strong lately' due possibly to some damage to the kidneys. But then it may have been due to the fact that she wasn't drinking enough water, for she told me that her doctor had told her to drink eight or ten glasses of water a day. The only other complaint she had was about her corn on the fourth toe of the left foot. She regrets that she didn't have something done about it before she broke her leg.

Her present chief complaint is an inability to move her left leg, and pain in that leg. Since she is getting worse and worse, or rather since her condition is getting poorer and poorer, she has more complaints now. Her left heel bothers her, and she has lost her appetite, and is nauseated following the pills she is given. Voiding did burn, but that is better now. She seems quite drowsy, but doesn't sleep well. Her prognosis is poor as this report will show.

The symptoms were pain in the left leg and an inability to move it. The signs were a tender lump in the left shaft as shown in the diagram. (In the original study, a diagram was included.)

Accompanying extra systolic murmur heard over entire precordium. Beat at left second costochondral junction. This was medium pitched and lasted through the first two-thirds of systole.

Peripheral vessels sclerosed moderately.

The lump indicated the area of the simple fracture. This was confirmed by x-ray. This is a common type fracture. Eliason,

Ferguson, and Farrand state that* "these fractures occur most frequently in old people, especially in women, and are due frequently to very insignificant injuries."

The presence, however, of arteriosclerosis is a complicating and dangerous condition. This is so because the condition predisposes the patient to the development of pressure sores that become gangrenous easily. That unfortunately is happening here in the case of Mrs. C.

The urinary condition does not seem to have affected the fracture place."

III. "The treatments are:

1. Reduction of the fracture.

An attempt was made to reduce the fracture by traction using a Kirschner wire which was put in place through the lower end of the femur under a local anesthetic. Traction is one method of reducing a fracture. The general principle behind all reductions is to replace the bone fragments in as nearly a normal position as possible, and then to maintain this position until healing has occurred. Several factors may complicate this treatment. A muscle spasm may greatly disturb the normal alignment. Traction, if successful, overcomes this by pulling on the muscles and bone until the fragments are aligned, and so prevents shortening. This was attempted in the use of the Kirschner wire. Sometimes traction is applied to provide pressure until the fracture is reduced, at which time the part is splinted to maintain the position until the healing has taken place. At other times, traction is maintained throughout the healing process. A second way to reduce a fracture is by open reduction. In this type, the surgeon puts the fragments in place through an open incision and then secures them by some appliance such as a metal band. This is referred to as internal splinting. My patient had to have an open reduction because the traction applied did not give a good alignment and it was found impossible to maintain the desired position. This reduction was frequently checked by x-ray. In fact this was the testing means by which it was decided that an open reduction was necessary. After this open reduction, Mrs. C. was put into a body cast or a Whitman spica. This is a cast extending from the waist to the toes of both feet. It is open at the groin and for an area over the buttocks; otherwise the patient is completely enveloped from her waist down. The legs are kept abducted, in a position sideways from the midline, and maintained so by a strong bar separating them. This is one of the most difficult types of casts to manage because it is bulky and hard to move about and the area of possible pressure sores is great.

* Eliason, E. L., L. Kraeer Ferguson, and Evelyn M. Farrand: *Surgical Nursing*, 6th ed., Philadelphia, Lippincott, 1940, p. 468.

Because of Mrs. C.'s age and because of the presence of arteriosclerosis, areas of gangrene developed on her left foot, first on her large or first toe, and then on the outer border, and finally along the tendon of Achilles. Parts of the cast were removed from about the foot, but despite our care, the condition continued to grow worse rather than better. Last night when Mrs. C. was turned so that her back could be rubbed, quite a lot of bloody pus was found to be oozing out around the open place at her buttocks. This caused some marked concern. Its cause was discovered later that evening when the entire cast was removed and a badly infected wound was discovered. Several of the stitches were removed and the free pus was aided in draining by some pressure over the surface, after a passage had been made for it by the insertion of a Kelly clamp into the wound. The patient is now on a Bradford frame with her left leg in a Thomas splint.

The ring fits up into the region of the groin; the frame is longer than the leg so that the foot is free. The webbing can be placed so that it gives support wherever it is desired and needed. Mrs. C.'s limb is kept in place by some wide gauze bandage which is rather loosely applied. There is a large pad of gauze over the wound which will have to be changed; however, the orders for this had not been written last night.

A Bradford frame greatly facilitates nursing care because it eliminates the lifting and moving incident to elimination and micturition. It is set up four inches above the mattress on two long wooden blocks.

A Balkan frame is also attached to this bed and by means of the hand rings the patient will be able to move her shoulders and trunk about a little by herself.

This case portrays, therefore, a good deal about the treatment of fractures, for traction, open reduction with body cast, and now a Thomas splint have all been used. Something also has been learned of the difficulties incident upon such a case, upon traction and something of the dangers and complications arising from a circulatory disturbance, namely, arteriosclerosis.

2. At first sedatives were ordered so that Mrs. C. would lie quietly. Codeine, grains one-half and later morphia, grains one-eighth, subcutaneously were ordered for the relief of pain, because these depress the perception of the sensory stimuli in the cortex. Hypnotics were also ordered; i.e., barbitol, grains ten at bedtime to help the patient sleep, which is one of the greatest curative agents because during sleep the anabolic processes have a greater chance to dominate than the catabolic changes, and so aid in building up the body's resistance and aid in the healing. Some wise doctor said to his students, paraphrasing Shakespeare, 'Sleep, blessed sleep who ravells

out the sleeve of tiredness; A quarter grain of Morphia, Gentlemen, a quarter grain of Morphia.'

3. Mineral oil and cleansing enemas were ordered as necessary because good elimination is essential to remove the toxic effects of foods and possible poisons and also because good elimination or bowel hygiene as it is sometimes put, is essential to healing. A patient who has to stay in bed quietly for a long period of time easily gets constipated.

4. At first a soft solid diet was ordered for the patient. This is an easily digested and consumed diet. The order was later changed to 'diet as tolerated' and still later to high-vitamin, high-caloric diet, which was ordered because the patient needs all the building materials possible to aid in the healing of the bone. Calcium is a particularly necessary item for lime salts must be deposited in the soft fibrous tissue of the callus which is first exuded about a fracture. These lime salts make the callus of the same consistency as the bone. A callus is the mass of healing tissue that is laid down around a break of a bone. Into it come the osteoblasts which are bone-forming cells, and also the osteoclasts which are the bone-dissolving cells. In this way, the amount and the growth of the callus is determined. Since milk is an excellent source of calcium, I always tried to see that Mrs. C. drank the glass of milk that was on her tray. Since milk is also a complete food, it could take the place of other things in the diet.

5. Boric ointment was ordered to be applied to the corn on the fourth toe of the left foot to soften the callus. The ointment was later alternated with warm boric compresses which were applied to the gangrenous areas that developed on the big toe. The gangrene was due likely to an obliterating endarteritis arising from the arteriosclerosis. The warm boric compresses aid in circulation by causing a local hyperemia which is a superficial dilation of the blood vessels. This allowed a little more blood to come into the part which needed the oxygen and the food carried by the blood, and needed the removal of the wastes of tissue life. Heat is the chief agent here; however, the boric solution has a slight antiseptic action. These compresses were applied with sterile technic.

Urine specimens were collected and sent to the laboratory for routine examination and for culture. The routine examination showed a specific gravity increasing from 1.008 to 1.022 with a slight trace of albumin in the last specimen and a marked increase in the number of white blood cells, i.e., from 3-6 to 20-60, in the last test. Also 2-3 red blood cells were found in the last specimen. Report on the urine culture had not been sent back. This indicates a definitely inflammatory condition somewhere in the urinary system. For this was ordered first potassium citrate, a diuretic, and later

methenamine, a urinary antiseptic. The latter tends to make the patient nauseated and causes a loss of appetite, both of which symptoms Mrs. C. has shown. She says the 'pills make her ill' and it is very difficult consequently to get her to eat.

On examination of the blood, it was found that she had a secondary anemia, as evidenced by the low hemaglobin, i.e., 66. Also, her red blood cell count was only 3,490,000 instead of the 4,500,000 which is normal. For this she is getting ferrous sulfate grains four, three times a day. Her white blood cell count was 13,000 at first, then it dropped to 10,000, but rose in the last day to 12,500, indicating a probable infection, which was found in the septic wound when the cast was removed last night.

Her temperature, on admission, was normal. Daily it ranged between 97 and 99.4, until the twenty-first of January or three days after the open reduction and the application of the Whitman spica, when it rose to 101 three nights, the fourth night it rose to 100, and the fifth (last night) it did not rise above normal by three p.m. It was thought at first that the temperature was due to the developing gangrene. Now it is known it was due to the infection. The fact that it was not a higher temperature and that it failed to rise on the fourth and fifth nights, indicates that Mrs. C.'s body is not setting up much reaction to the infection.

I feel like saying at this point that these treatments seem to have made little impression on Mrs. C.'s general condition, which is certainly not improving. But then, one must remember that here we are dealing with a seventy-five-year-old patient, whose disease is complicated by her arteriosclerosis, secondary anemia, and some inflammation of the urinary system. The methenamine grains ten, three times a day is given to help prevent the spread of the inflammation and to disinfect the urine, which may be causing it."

IV and V. "Nursing Care and Problems: The 'routine' nursing care consists of:

- Four-hourly temperature, pulse, and respiration
- Three baths weekly
- Four-hourly back care daily
- Noting the voiding
- Forcing fluids and measuring and recording intake and output
- Medium headrest
- Turning on alternate sides
- Special heel care
- High-vitamin and high-caloric diet.

By means of the information gathered by the four-hourly temperatures, we were able to follow the body's reaction. As has been

noted, the rise in temperature along with the blood count led us to suspect an infection. The fact that the elevation was not maintained showed that the reaction was poor.

Three baths weekly were given to help keep the patient's skin, that was exposed, clean so that better elimination could be maintained through it. It is also more comfortable for the patient to be clean and free from the oil and sweat that accumulates even in healthy people.

Back care was done to harden the skin with alcohol and to encourage circulation by the mechanical means of massage which is appliance of pressure by the hands. This stimulation of the circulation helped guard against pressure sores. Since this was a good time to turn the patient, the two things were done at once, usually. It was very important to turn the patient, for otherwise she would be likely to develop hypostatic pneumonia.

Fluids were forced to dilute the toxins of the disease, to aid in elimination, and to keep the patient from becoming dehydrated. They were especially necessary here because of the urinary complication.

The intake and output were measured and recorded so that an accurate record of how much was coming back and a knowledge of the kidneys could be gained. A normal intake and output curve was found. The intake was from 1750 cc. to 3000 cc., and the output was from 600 cc. to 1300 cc.

Careful observation was carried on to note the development of any pressure areas and these were reported and pillows or cotton applied to relieve the pressure.

Special heel care was given to keep the skin of the exposed foot as soft and pliant as possible.

Both feet were rubbed daily with lanolin to keep the skin soft and free from breaks.

Mrs. C. had to be fed. It was difficult for her to manage even sips of water due to her position in bed. Even the medium headrest did not help her in this respect. Her pitcher was, however, always left near so that she could get it if she did want some water. However, one of us tried to see that she got a drink each hour, for we were trying to force her fluid intake up to over 180 cc. an hour. It meant frequent trips there and holding the pitcher in the best position possible so that she could get a steady stream of water with no air bubbles. Happily, she is fond of cold water, and also because she has always followed whatever she was told to do, she would drink all that she could at one given time. However, when it came to eating, the story was altogether different. She just didn't seem to eat. One used all her persuasive powers to get her to take a few swallows of egg and a glass of milk. When she had what she thought

was enough, she told us that that was all, and there was no changing her mind. She caused me much concern because she just wouldn't eat. Sometimes she would eat nothing, promising vaguely that she would in the morning or later, but not just then. This problem I just never did solve, or rather I haven't solved it yet.

As Mrs. C. grew sicker, she seemed to shrink into herself. She had a habit of pulling the bedding up so that only the top of her head showed. Once I asked her if the light bothered her, but she said that it didn't. She used to lie for long periods like this, apparently asleep, and yet when you spoke to her she answered as if she had been awake all the time. I thought that she was probably off in the past dreaming, and her dreams were her own. Often I hated to disturb her. Once I was applying some ointment to her heel when I thought she was peacefully asleep, but to my surprise she said, 'That feels good—only it hurt a minute ago.' She had spoken of a place that I felt sure was rubbing against the cast. So I concluded that she probably was more aware of the things going on about her than I, at least, had realized.

We kept both her legs off the bed, supported on pillows the last day or two. This was to aid in the venous return and so to prevent swelling. Also it helped stir up the whole circulation because blood returned from the extremities finds its way to the heart, to the lungs, to the heart, and thence back to the extremities. Against the Balkan frame on the left side, we placed a pillow so that it supported her foot in an upright position, that is, at right angles to the rest of her leg. This was both the most comfortable position and one that actively prevented toe-drop by maintaining the normal position of foot to leg. A cradle was also used for two reasons: to keep the covers off her feet, and to supply heat to help with the curing of the gangrenous areas. Heat stimulates the circulation so badly needed here.

A medium headrest was used with the aid of one pillow and so placed that the normal cervical curve was maintained. A small pillow was sometimes applied to the small of my patient's back to help maintain the normal lumbar curve. The frequent back rubs did much to rest Mrs. C.'s back as well as to ensure that she was turned. It really took at least two nurses to turn her over, so that one of us could inspect her back. She enjoyed these so that I sometimes gave her one that was extra long, and one that went way up on to her shoulders and the back of her neck. When we were going to leave her on her side, we would turn the footstool on end and put a pillow on that to support the leg which was uppermost. Then we would place two or three pillows along her back for support. She didn't like lying on her abdomen, for her head was at too much of an angle, and therefore was not at all comfortable.

Mrs. C.'s teeth were all false and lately she has been keeping them out of her mouth. They seemed to be such a bother to her. In the afternoons, I would wash her face with gauze and just water, for her skin was naturally dry and the hospital soap seemed to dry it even more. Then I would try to get her to rinse her mouth out with some of the mouthwash I had brought. Two successive afternoons I carefully showed her the motions, going through them myself as well as telling her about them. She did quite well on the rinsing part, but very poorly on the emesis part. She never did get the knack of letting it roll out of her mouth into my carefully placed basin. I often wondered if I were going to catch any of it at all. Once I had to change her nightgown, she expelled it so violently. She didn't care much for the taste of the mouthwash, I knew, for she made a few faces over it. However, I let her rinse her mouth thoroughly afterwards with water and she said later that it tasted better.

It was found advisable to powder carefully under her breasts, for they were large and places of excoriation seemed imminent. In fact one did appear, and zinc oxide ointment and thymol iodide powder were applied to hasten the healing.

Yesterday, as Mrs. C. had much more pain, we gave her the aspirin, grains ten every three hours. We attempted to add to her comfort by keeping her as clean as possible, rubbing her back, fixing her pillows, and protecting her eyes from the light. We also tried to keep the air cool and humid. The aspirin did not relieve the pain, however."

VI. "Future Needs of the Patient:

As I have said before, the prognosis for Mrs. C. is very poor and is daily getting poorer. Whether the change to a Bradford frame and a Thomas splint will stem the tide of downhill changes remains to be seen. Just what the septic wound will mean is also unknown, and just how extensive the gangrene will become is problematic. If, in spite of all we have done, she doesn't develop hypostatic pneumonia, I will consider her most fortunate. Mrs. C. is likely to be critically ill for some time as yet. There is of course the question of what is going to result from the gangrene. Those areas which are already gangrenous will never be restored and these are scattered over her left foot. Then can one be sure the fracture will heal? One thing is sure, and that is that Mrs. C. in the immediate future and the distant future is too problematic and uncertain to even dwell on just now.

If Mrs. C. should completely recover, she would have to make quite a readjustment. I doubt whether she could continue to work. At least it would have to be very light work. I frankly don't know

what resources she has as savings, nor how far her employer would carry her.

At times, I almost think it would be a blessing for her to join those many friends and her few relatives, for should she live, she would be a very lonely old woman."

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Conferences: Head Nurse
Supervisor
Interne

Acute Ulcerative Colitis

A Medical Nursing-Care Study

By a Second-Year Affiliating Man Student

"This is a nursing-care study based upon the case of Mr. N. while he was a patient in Ward 7 following his admission in March, 1941.

Mr. N. is a young white male, aged 18 years. He was born in Hollywood, Ireland, of Scotch-Irish parents. For several years, however, he has resided with his parents at B. St., R., Massachusetts.

The family consists of Mr. N.'s father, mother, younger sister, and a maiden aunt who lives with them. They are very stable in personality, and are looked up to in the community from which they come. The father is a very capable machinist and has carried on his trade all his life. He has been successful enough at it to earn a very comfortable living for his dependents. The mother is a very neat and attractive person, but is so deaf that she is unable to carry on any conversation to speak of. She is acutely sensitive of her affliction and has shut herself off from the rest of the world. To make up for the lack of social activities in which most women indulge, she has devoted her entire being to caring for her home and family. This, no doubt, explains some of the difficulties the nurses have met with in caring for Mr. N. More will be said of this later.

Mr. N. is a young student and has only recently graduated from the R. High School. Throughout the entire school period he has shown himself to be very brilliant and studious. His marks in all subjects were always in the higher level. He is interested in education and is hopeful of being able to attend B. University, and then

enter the teaching field at a later date. He has mentioned the fact that he would like to study medicine and become a doctor, but feels that he has been too much of a burden upon his family, and as a second choice he now feels that he would like to teach history.

As for personality, it is obvious that this patient has had the benefit of a cultured and refined home. His speech is moderate and well modulated, but sometimes one has the feeling that everything he says is weighed well in advance of its expression. For this reason he may appear to be reticent and somewhat aloof. Because of this and his great interest in books and studious pursuits, he has failed to cultivate interests in young people of his own age. It must also be remarked at this time that symptoms of his illness have been present off and on for the past five years and have, of necessity, restricted his activities because of the absolute rest which is so essential in the treatment of his disease. These past five years cover a period of life which is commonly marked by states of confusion and uneasiness in the nervous temperament of most youths. When one considers this fact and combines it with his illness and natural trend to more quiet pursuits, it is small wonder that the patient is not more introverted than he already is.

He is always very congenial and agreeable when approached, but he never makes any attempt at light talk which is so common among active people. Plays, fiction of the romantic type, or poetry, have little interest for him. Moving pictures fall into the same category. Only such movies as are based upon historical plots are interesting to him. Magazines which are concerned with social and political affairs hold a more prominent place in his estimation than those with the current novels and plays of the latest writers. No radio program of music seems to ever intrigue him regardless of whether it is of the classic, semi-classic, ballad, popular, 'swing,' or 'jazz' type of music. The minute that some discussion is presented, or current events are broadcast, he becomes very keen and alert, and is glad to converse with others about it if they will only open the conversation.

This patient also has a younger sister who has presented conflicts in his life. She is a very active girl, with many outside interests. Also, her activities in the home and her ability to do heavier tasks have been a great trial, as he is very conscientious and anxious to do his share of the work, and feels depressed when his activities are restricted. He has always been deprived of the satisfaction of doing something to earn money that might be called his own. He has told me of doing such things as mowing the lawn when the rest of the family left him alone for short periods of time. On another occasion, he expressed his desire to help by painting the porch floor, when he had been forbidden to do work of any kind.

Perhaps he was forced to feel this way by the attitude of his father. He is a very active man who has achieved some success in his particular trade, in spite of lack of education, which he has supplemented with courses taken at night school. Like many people of this type, he could not understand why other people shouldn't do likewise. At first he was prone to criticize his son when the latter complained of not feeling able to do whatever had been proposed for diversion or entertainment for the rest of the family. This attitude has been corrected on the part of the father and in talking with him I have been able to see that he fully understands his son's condition and feels badly about his hastiness in the past. However, I'm afraid that many of the patient's anxiety problems were intensified by these past incidents.

The intelligence of the patient is marked to a very high degree. His ability to interpret and carry out instructions would emphasize this fact. He is intensely interested in his condition and is very willing to co-operate with the treatments. I do not think that he realizes what an operation like an ileostomy would do to him, but I am quite sure that if it is approached gradually and explained fully, there need be no difficulty in convincing him that it is quite a possible and not too drastic a procedure. I feel that this patient's high degree of intelligence has prevented him from becoming irritable and unpleasant as so many patients do with a similar condition.

From early childhood, this patient has always been more or less underweight even when he appeared to be perfectly well otherwise.

In 1934, at a local hospital, a tonsillectomy, with removal of the nasal adenoidal tissue was done and was felt to have been a very satisfactory procedure at the time. Previous to this operation, the patient had had a chronic involvement of both ears, with very purulent discharges. This was relieved following operation, and an uneventful recovery followed.

Since the family had friends in the service of the local dispensary, the patient was referred there for advice and treatment early in 1936, when he developed symptoms of occasional cramping pains in the region of the umbilicus and profuse diarrhea. There, it was found that the stools contained blood and he was referred to the Massachusetts General Hospital for examination, diagnosis, and treatment.

In May, 1936, Mr. N. was admitted to this hospital with a history of nausea and vomiting on one occasion, cramp-like pains in the region of the umbilicus for the past six weeks, a very prostrating diarrhea with macroscopic blood in the stools, and a very marked loss of weight. Bed rest was instituted at the very beginning and several proctoscopies and barium enemas were done to aid in diagnosis. Ulceration of the lower two-thirds of the large bowel was

plainly shown. Occasional positive 'guaiacs' were reported during this admission to the hospital. This test is done to show the presence or absence of blood in the stool. He was given a stage III colitis diet and did fairly well. This diet consists of bland, low residue and non-irritating types of food. At the same time, emphasis had to be placed on the presence of adequate proportions of all nutritive essentials and rich amounts of the various vitamins. Milk, boiled or peptonized, toasted white bread, highly milled cereals, eggs, soft cheeses, tender lean meat such as chicken, boiled fish, puréed vegetables, strained fruit juices, strained cooked fruits, and strained tomato juice are among the foods commonly given in this type of diet. Vitamin content may be increased by giving cod liver oil, haliver oil, betaxin, thiamin chloride, cevitic acid, and brewers' yeast. Because of some familial history of allergy, sensitivity tests were done. He was found to be negative to all common foods. In June, 1936, the patient was discharged home with limited activities and the diet mentioned.

In January, 1939, this patient was brought to the Psychiatric Clinic and appointments were made at brief intervals in order to try to assist him with the difficulties and problems which were presented in the course of his chronic illness. It was also felt by the patient's parents that their son was somewhat undeveloped and immature. It may be interesting to note that Mr. N. was only 16 years of age at this time. The only note that the psychiatrists had to offer in regard to this patient was that he was unusually shy and self-centered. It seems that any contact with the opposite sex was very distasteful and boring to him. The doctor who interviewed him in the clinic remarked that due to recurring attacks of colitis and diarrhea, the patient of necessity had to be secluded. Due to this fact, when he did encounter such situations and was brought face to face with society outside of his own family, he was at a total loss to know what to do or say. This state of affairs no doubt only caused him to withdraw even more into his 'shell.' These interviews were carried out at irregular intervals due to the inability of the patient to keep his appointments because of frequent illness. The patient was noted for his frankness, spirit of co-operation, truthfulness, and reliability, and at no time seemed to have felt any embarrassment from attending such a clinic. Rather, he appeared to appreciate the opinions and advice of the doctors and was intensely interested in everything that was done.

In July, 1939, this patient was brought to a local hospital for a tonsillectomy. This was done because portions of lymphoid tissue were a constant source of infection, and he had had sore throats with frequent colds during the preceding winter. Recovery was uneventful, and he was discharged home to his local doctor.

This past winter the patient has noticed that he is very susceptible to colds and in spite of precautions, he suffered from many of these infections. Frequently these colds caused an exacerbation of symptoms in connection with his chronic ulcerative colitis.

Shortly after the first of March, this patient came to this hospital for a barium enema. This x-ray examination showed that there were many ulcers from the cecum to the rectum. It also showed that the lower part of the ileum was involved. He was advised to come into the hospital for observation and treatment. His story revealed upon admission that he had had a flare-up of his colitis about six months before, with abdominal cramps, nausea, and vomiting.

This young man's history shows that he has been very uncomfortable for a long time and has carried on his school work only under great difficulty and tremendous nervous strain. It is small wonder that he is very much run down at the present time.

As soon as the patient was admitted to the ward, he was put on absolute bed rest to allay activity of the bowel and to keep peristalsis and muscular motion of the bowels as quiet as possible. This was desirable to lessen the irritation of the ulcerated areas. In cases of this kind, ulcers will heal over and symptoms disappear as long as rest is maintained, but frequently recur as soon as activity is increased.

The diet given him was a high-vitamin, high-caloric, low-residue diet and very similar to the one previously described. It was supplemented medically by the various synthetic preparations of vitamins. Cevitamic acid 25 mg. t.i.d., betaxin 5 mg. t.i.d., and haliver oil capsules iii q.d. were given to supply vitamins C, B, A, and D respectively.

Vitamin A is necessary for the maintenance of the normal covering of the body and the mucous membrane lining the cavities and ducts of the glands. Obviously, then, it is important in healing wounds in these structures.

There have also been experiments performed which show that Vitamin A bears a relationship to the reticulo-endothelial system which is a very important defense mechanism of the body. Wilbur and Eusterman have reported several cases of night blindness due to deficiency of Vitamin A.

Deficiency of Vitamin B can produce a disease known as beri-beri and it has long been known that patients with beri-beri do not stand surgical procedures well. It seems that several factors of Vitamin B (B_1 - B_2) have a catalytic function in connection with carbohydrate metabolism. Cases of peripheral neuritis and polyneuritis have been reported due to deficiency of this vitamin. It is also helpful in overcoming anorexia and this is certainly to be hoped for in this

patient because his appetite is anything but good, and he has always been somewhat 'finicky' in regard to eating.

Vitamin C, sometimes referred to as ascorbic acid, is intimately related to production of fibrous tissue and is an exceedingly important factor in the repair of wounds and broken-down areas. One authority suggests that all surgical cases should be tested for the presence of Vitamin C in the blood preoperatively. Also, that when the percentage is less than 1 mg. per 100 cc. of blood, the vitamin should be given daily to make up for the deficiency.

Vitamin D is essential to normal calcium and phosphorus metabolism. Deficiency of Vitamin D leads also to excessive bleeding and hemorrhage due to impaired clotting time and also has some relation to scar formation.

Ever since his admission in March, Mr. N. has had a very bloody diarrhea, sometimes having as many as six or seven bowel movements daily. For this condition, he was given deodorized tincture of opium after each bowel movement. The dose to start with was five minims by mouth and when this was found to be inadequate, it was increased to 10 minims and still later, 15 minims. At this time, it was noticed that the patient became very groggy at times and it was specified that deodorized tincture of opium was not to be given more often than once an hour, but this caused no difficulty because his stools, by this time, had become less frequent and occurred only twice to three times daily. Bismuth subcarbonate was given also in doses of one dram t.i.d.

Deodorized tincture of opium is used when it is desirable to lessen peristalsis and produce a slight constipation. It also lessens intestinal secretions and is valuable in checking diarrhea for this reason.

Bismuth subcarbonate is an alkaline astringent and is used principally to coat, protect, and heal ulcers and as an astringent to check diarrhea. It also has a tendency to lessen nausea and vomiting, if these symptoms are present.

After about four days' stay in the hospital, the patient contracted a cold and developed a sore throat. He was immediately put on streptococcic precautions and absolute isolation. During this period, he had great malaise and a throbbing headache, so empirin compound was prescribed and it seemed to relieve the patient very readily. This is one of the more recent drugs and is compounded from acetylsalicylic acid, caffeine sodiobenzoate, and acetphenetidin. It stimulates the circulation, reduces fever, and is very good for the relief of neuralgic pains and colds.

Codeine sulfate was given to depress the cough reflex. Codeine is a preparation of morphine and has the advantages of not depres-

sing the respiratory centers and also is less likely to become habit forming.

Several laboratory findings were reported that are of interest in the case. The red cell count was found to be 5,950,000 with a hemoglobin of 60 per cent and marked microcytosis. The red count was somewhat above normal and the hemoglobin was quite low and indicative of a pronounced anemia, which is not to be wondered at when one considers how long blood had been escaping into the intestinal tract because of the severely ulcerated areas in the colon.

Microcytosis is a condition wherein the cells are abnormally small and shrunken in appearance. This is a condition which occurs when excessive demands are placed upon the red cell production centers of the bone marrow. The red cells are released into the blood stream before they are fully developed.

Frequent stool cultures were done, but no pathologic organisms were found. However, every specimen of stool did show macroscopic presence of blood to the extent of large clots as long as two or three inches.

In March, 1941, a blood serum test was done to determine the amount of proteins present in the blood stream. It was found that the blood serum contained 5.5 Gm. per 100 cc. The usual normal content is considered to be around 7.5 Gm. per 100 cc. of blood. It is important to know this because protein content is indicative of the body's ability for growth, energy, and the power to regenerate new tissue. It is also connected with the clotting ability of the blood. A decrease of protein content in the blood stream increases the clotting time. This is very important in a case where great hemorrhage has been present. Perhaps this is why the patient has a tendency to bleed so profusely from his ulcers.

Another proctoscopy showed extensively ulcerated areas in the upper regions. As the proctoscope was withdrawn, the mucosa of the lower colon was shown to be very rough and much granulated matter had formed. It was decided at this time that the patient not only had an extensive ulcerative colitis, but also a pronounced anemia due to the constant loss of blood through the lesions of the ulcers. The treatment at this time was an increase in Vitamin B content to be given parenterally and blood transfusions every other day. After this was done, blood count showed the red count to be 6,000,000, with a hemoglobin content of 88 per cent. This was an increase in both constituents, especially in the hemoglobin content. In a few days, this procedure was repeated; the red count stayed about the same (6,020,000) and the white count was 14,500, which is quite a bit above normal. The hemoglobin, however, was somewhat lower than two days before (80 per cent). Transfusions were continued but at this time no reports have been returned as to their

specific benefits. The primary reason for these was to build up the patient so that he would be a better risk for operation in case an ileostomy was decided upon.

A few days later, a throat culture was taken and hemolytic streptococci in abundant growths were found to be present.

With the next transfusion, a one gram ampoule of cebione was added to the solution. This is a preparation of Vitamin C and is an important factor in the control of hemorrhage by decreasing the clotting time.

Beginning in April, the patient was given phenobarbital grs. $\frac{1}{4}$, 4 i.d. This drug is a hypnotic and affords the patient a deep relaxation. It slows muscular twitchings and makes the respiration slower, deeper, and more regular. It also lowers blood pressure and lessens nervous symptoms. Thiamin chloride in one milligram ampoules was another form of vitamin therapy which was started. This was given once daily subcutaneously to hasten absorption of the vitamins into the body.

The patient was quite co-operative with all of his treatments, but seemed to be quite upset by the fact that he had to have so many transfusions. As he expressed it, 'I'm afraid that the expense of these transfusions will inconvenience father and perhaps some of the others will have to do without things they need in order to provide me with these things. I feel as though I were an awful burden to the rest of them.'

The routine care of this patient consisted principally in bed baths, mouth care, care of the hair, finger and toe nails, heels, and special back care with attention to the bony prominences of the shoulder blades and coccygeal region.

Baths were a special problem to this patient because he was so weak that he didn't feel able to bathe himself, and embarrassed to have women nurses care for him. When I found that he did not mind having a man nurse bathe him, I instructed him to call one of us to assist him. It seemed to relieve his mind to think that such assistance was available.

When back care was given, a small amount of lanolin was put on the bony prominences and rubbed in thoroughly. The elbows and heels tended to become reddened. However, when lanolin was applied, this cleared up readily.

This patient was somewhat backward about taking fluids, and the importance of this had to be explained to him. Water, however, was somewhat distasteful to him in large amounts, so care was taken to vary this with other fluids such as milk, ginger ale, concentrated fruit syrups with water, and fruit juices. When this was done, he took fluids much more readily.

Another thing that this patient was anxious to have done was

mouth care. He greatly appreciated having fresh water to use after this procedure. Following the use of his brush, he liked to have it rinsed and put back into some kind of a wrapper to prevent soiling. Also, during the course of the day, frequent mouthwashes were a great source of comfort in that they cooled and refreshed his mouth and throat. Sometimes, the lips also tended to become drawn looking, so cold cream or mineral oil was applied to prevent any cracking or soreness of the area. A few drops of mineral oil applied to the tongue and rubbed well in with a cotton swab on a small stick did the same thing for his mouth dryness and irritation. When this patient developed his sore throat, hot aspirin solution was used for gargles. These apply heat to the swollen lymphatics and increase the blood supply to the part, thereby aiding the blood cells in their combat against infection. However, this type of gargle does not have too pleasant a taste, and leaves the mouth and throat with a sensation of puckering. To relieve this, a small amount of some pleasant tasting mouthwash should be used. This patient seemed to enjoy the liquor antisepticus alkalinus best of all.

Shampoos followed with a brisk rub and massage of the scalp seemed to relax this patient to a marked degree. A very few drops of mineral oil applied to the finger tips and well rubbed into the scalp restored some of the natural oils which are depleted with washing. It also relieves dryness and scaling of the scalp which was present in this case. This also made it easier to comb the hair and keep it in place, which was very important to this patient because of the fastidiousness to which he has been accustomed.

Another thing that was needed was cutting of the nails. The fingers were not so difficult to cope with, but his toe nails had a tendency to grow long and sidewise so that the nail of one toe tended to push over against the flesh of the proximal toe and cause a raw, reddened area. I instructed the patient as to the importance of cutting the nails straight across and inserted small strips of absorbent cotton between the toes to relieve the irritation. I also mentioned that he should be careful in selecting his shoes, and to make sure that the toes were not pointed or narrow.

When the intravenous solutions and transfusions were given, it seemed to tire the patient a great deal to maintain a fairly steady position for the arm with the needle. As he refused to have an arm board applied, I found that support with pillows along the entire length of his arm relieved him greatly. After the infusions were completed, the patient seemed to be very much worried about the danger of infection entering where the needle was withdrawn. On one occasion, he kept a sponge on his arm for hours, and seemed to be still worrying about it. I was able to overcome this easily and quickly by putting a sponge dampened in alcohol over

the needle before it was withdrawn and then putting a coating of flexible collodion over the opening. This satisfied the patient, and did much to relieve his anxiety.

During the time when the diarrhea was so bad, this young man developed a sore, inflamed area in the anal region. This disappeared soon with the application of cold witch hazel compresses followed by glycerin, rubbed into the reddened area and then well powdered.

As this patient had a very sensitive skin, and became irritated easily, it was also necessary to keep his bed comfortable. His bed became very mussy during the course of the day because of his restlessness and general malaise. Frequent tightening of the draw sheet and brushing out of crumbs when present only took a few minutes and seemed to refresh the patient greatly.

After bowel movements the patient seemed to be very much upset unless he had facilities for washing and completing his toilet.

Due to the fact that the patient was put on precautions as soon as he developed a cold, everything had to be kept at his bedside and precautions carried out to prevent spreading the infection elsewhere in the ward. The bed-pan and urinal at the bedside seemed to bother the patient at first, but when this practice was explained, he offered no further comment and only asked that the pan and urinal be sterilized at least once a day thereafter. He was careful to save his papers and kept his pan and urinal covered at all times so that the covering was easily disposed of when it left the unit.

Occupational therapy was tried on this patient and it did seem to interest him. He made a knotted belt which was very attractive and practical, but much occupation in this field was impossible because most of the time he felt too weak. As soon as he began to recover, his interest in current events livened and regained a foothold in his mind.

The future needs of this patient, of course, depend upon what is decided to do with him. An ileostomy has been proposed as soon as the doctors feel that the patient is a good operative risk. He does not know that the operation has been proposed, but he has little idea of what is involved and how it will affect him later. I do not believe that now is the time to discuss the probabilities of the outcome because he might dwell upon the matter and thwart his own ends by so doing. As it is now, he is perfectly agreeable and co-operative with his treatments and possibly it is better to 'leave well enough alone' and maintain his peace of mind by so doing. Emotional stability cannot be rated too highly in the efficacy of procedures both pre- and postoperatively.

When the patient does come to operation and after the ileostomy has been done, it seems to me that little by little the nurse should

explain the mechanics of the operation to the patient. Perhaps the first step would be to instruct the patient as to the care of the ileostomy and to try different ways of adapting the dressing to the patient's own personal needs. Care of the skin should be stressed to prevent the patient's becoming lax in this respect later. Some find that aluminum paste forms a very good protective covering around the ileostomy to prevent digestion of the skin contents by the enzymes and pancreatic secretions which are in the bowel content. Another product which has worked very well in some cases is zinc oxide ointment. This works still better in other cases when combined with lanolin in equal parts.

The next step would be to explain to the patient how he may care for these discharges later with an ileostomy bag of some sort. It is always well to have the patient understand that bags are of little avail until recovery is fairly well completed and the body has regained its normal shape and size to ensure the permanent fitting of such a bag.

When it is explained that other patients have had the same thing and gone back into society while maintaining their work-day activities, a more philosophical outlook on the part of the patient may be produced. Selected articles relating to this procedure would be valuable to a patient of this kind because he is very much interested in his condition and I think that he is the type who will make a success of such a procedure.

Perhaps a talk with the parents would also be advisable and I feel that they too should know all about what this treatment involves and why. If this is done they can more intelligently supervise the patient as regards his diet, activity, etc. It must also be remembered that this patient has the productive period of his life ahead of him. This has its advantage in that his future can be planned for now and due consideration given to the limitations involved so that a period of readjustment will not have to be carried out later.

What this boy needs is friends to help him mature and develop an interest in something outside the confinements of his family life. His peculiarities are not so much peculiar manners or eccentricities of the mind as they are lack of training in public life and an ability to contribute something to society. As long as this boy comes from a family which is active in the church, it seems that perhaps he might be able at a later date to enter into some of the activities of the Young Men's Association and Youth Movement Groups which are always found in a community church such as he belongs to.

At a later date and after having recovered sufficiently from his treatment, I think that a period of interviews with the Psychiatric Clinic in the Out-Patient Department would be of great help in

drawing out this boy's possibilities and developing the 'savoir faire' so that he may hold his own in society.

Perhaps he might even be persuaded into taking his sister with him to some accredited school of dancing and opening up a new field of acquaintances and interests through the contacts which he is bound to make in such an environment. However, until such time as operation and recovery have been instituted, symptomatic treatment with tranquillity of mind is in order."

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Pituitary Dysfunction

A Medical Nursing-Care Study

By a Second-Year Student

"M. DiM. was born in Boston of Italian parents in 1926. Her mother was young and this was her first baby. M. DiM. was a full-term baby, but the mother had a very difficult delivery necessitating the use of forceps, and there is a possibility that the baby was injured at birth. The baby weighed only three and one-half pounds. When she was two weeks old, she developed a 'blood tumor' (so called by Mrs. DiM.) on the top of her head. Her mother noticed it but paid little attention and did not take her to the doctor. The baby appeared to be healthy; she ate well and grew normally. When she was ten months old, she began walking. Mrs. DiM. decided that something should be done about the baby's head so at 11 months the baby was taken to the doctor. In his office, the 'blood

tumor' was removed. The baby's appearance was improved, but after this the mother noticed that the baby fell down easily.

M. began to talk when she was one year old. She gained steadily in weight and developed normally until she was six years old. Suddenly at six years she seemed to stop growing. At first the standstill was not apparent, but even when it did become noticeable the mother did not seek medical help for the child. She went to school and passed every year, so that at eleven she was in the fifth grade in school. At this age, her six-year-old dresses still fitted her.

The school principal noticed that she was slow in school and that she couldn't quite keep up to the others in her grade. He advised M.'s parents that she should have a thorough medical check-up to see if there wasn't an underlying cause for her slowness. Mrs. DiM. brought her daughter into the Children's Medical Clinic of the Out-Patient Department. Mrs. DiM. told the doctor that M. was dull most of the time and was always dozing off. These signs she had attributed to the 'blood tumor' that was removed from the child's head, and this is the reason she had not consulted a doctor about them before the present time.

Physical examination showed an eleven-year-old girl only $45\frac{3}{4}$ inches tall, weighing only $47\frac{1}{4}$ pounds. She appeared well nourished and well proportioned, but much nearer a six-year level than her eleven years in physical development. The diagnosis of pituitary dysfunction was made.

In the summer, when M. had finished the fifth grade, she was brought into the children's ward for study. X-rays were taken of her skull and pituitary glands, and showed nothing remarkable. X-rays were taken of her long bones to determine their growth development and these showed that her bone development was the same as that of a six-year-old child. Dental examination and x-rays were consistent with the general physical findings. In Thyroid Clinic, her basal metabolic rate was found to be lower than normal and thyroid therapy was advised. She was given an intelligence test which showed her mental age to be nine years. Her intelligence quotient was 73, and she was placed in the borderline defective diagnostic group.

Following these studies the diagnosis of pituitary dysfunction was confirmed; the findings showed that there was pathology of the pituitary gland. In health, it is essential that this gland is working efficiently, for it is the master gland of the body. . . .

M. was sent home after a week's study to come back regularly to the Children's Medical Clinic of the Out-Patient Department. She was followed by Dr. Z. with thyroid therapy and by the Eye Clinic because of a question of early papilledema. She was given glasses to correct her vision. At home she was to have a nutritious

diet supplemented by yeast cakes and cod liver oil. She was given thyroxin, grains one-fourth, to be taken every day. That fall she had to repeat the fifth grade, but she did very well.

In the next year, M. gained an inch and three-quarters in height, and two and one-half pounds. This is, of course, very slow—about one-half normal growth rate for children her age—but when one remembers that for five years she didn't grow at all, it seems remarkable. Her mental ability seemed to increase as she grew. She passed the sixth grade and was promoted to the seventh grade on trial. She did well in the seventh grade, and she is now in the eighth grade doing fairly good work.

At 14, M. began menstruating irregularly; so far, there have been no corresponding secondary developments. She had periods of weakness and she tired easily. She was referred to the Ovarian Dysfunction Clinic and together Dr. P. and Dr. F. have made a plan for her which they believe will help. She was to be given ten milligrams of oreton three times a week. After three weeks on this regime, she feels stronger and doesn't get so tired climbing stairs between classes at school.

Oreton or testosterone is generally recognized as the true male sex hormone. Extensive clinical tests have confirmed the results of animal experiments which show that oreton is the most potent male hormone available. It is a thick, oily, colorless fluid. The usual dose is 10,000 Allen-Doisey rat units—five milligrams. It has many uses in the male, but it is also used for the female in cases of menorrhagia, dysmenorrhea, menopause, and inhibition of lactation. The solution comes in small ampoules and is administered intramuscularly in the deltoid muscle of the arm, the next in the other arm.

Earlier this year, M. had bad 'stomach trouble,' and she came into the Surgical Clinic. She complained of abdominal pain and after examination it was found to be caused by marked constipation. The doctor advised mineral oil and regulation of bowel habits. She went home and followed this regimen and has had no more abdominal pain or discomfort. . . .

I think M. has adjusted very well to her illness. She seems to be a very independent little girl who wants pity from no one. She has a grown-up manner which sets her apart from children of her size. She gets along very well at home, helped especially by her mother. She keeps to herself most of the time, but when she does play with other children, she chooses playmates who are her own size rather than her age, for she does not look conspicuous here.

She has one brother, thirteen, and two sisters, one twelve, the other four and a half. They live in the North End of B., on the top floor of an old tenement house. There are five rooms to the apartment and six people in the family. Although this district is not de-

sirable for the children, there is a playground near by where they play and get plenty of sunshine. Mr. DiM. is working and he is able to support his family without outside help. All the children, except M., are normal and healthy. Mrs. DiM. is concerned over M.'s lack of growth and she is interested in helping her daughter all she can. She brings M. into the hospital for her appointments, or if she is unable to come with her, she sends a note of explanation.

To secure treatment, M. must come into the Out-Patient Department regularly, which entails some expense. Transportation presents no problem, for she lives near the hospital. She does not have to pay the usual fee of \$.25 for admission, subsequent to the first visit, because she obtained from the Out-Patient Department supervisor a free clinic pass. This means she can come in for her hormone injections free. She must pay the cost of her thyroid and yeast tablets, but she does not have to pay for the oreton she receives. This is given free to patients in Dr. F.'s clinic. . . .

From a public health aspect a very important point is the early recognition of pituitary disturbances. There are an infinite number of grades of disturbed pituitary, with endless variations and alterations of hypofunction. These lower grades are the important ones to recognize, for only in the pre-structural change conditions can results be accomplished short of surgical interference. The symptoms of pre-adolescent hypo-pituitarism are small stature, ununited epiphyses, small sexual organs, skeletal muscle weakness, malformed, crowded, irregular teeth, potential weakness of bladder wall, high sugar tolerance, crying on slightest pretext, cowardliness, dryness of skin, subnormal temperature, slow pulse, and low blood pressure. In girls after puberty, there may be amenorrhea. Sluggishness of personality is the outstanding early symptom of hypothyroidism.

As a child, M. displayed almost every one of these symptoms. If she had had treatment before she was eleven, her prognosis today would be better. Now everything possible is being done for her and this treatment will be continued. As she becomes older she will find it more difficult to accept her limitation, but she has to live with her condition. Her family can help her a great deal by treating her as a normal girl, making her accept her condition, and showing her that she can lead a happy, useful life."

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Chorea

A Pediatric Nursing-Care Study

By a Third-Year Student

"May T. is an Italian girl of eleven or twelve (she and her father seem to disagree) who was brought into the Out-Patient Department with chorea, a form of rheumatic fever, and immediately admitted to the children's ward. Although May is extremely thin and rather sallow under her dark skin, and has the pointed chin and longish nose of a gypsy, with her fine large brown eyes she is almost pretty, especially when she is fixed up in her pink In-Bed-Club jacket and her straight black hair is softly curled. When she first came to the ward she would only hang her head and cry and reiterate shrilly, 'I want to go home.' Throughout her stay here she would get spells of repeating, 'I want to go home' in a stubborn, unreasoning way that made me conscious of a part of her that an outsider could not get at. Nevertheless, on the whole she soon became very friendly and co-operative and seemed like one who wanted to be taught and guided. These qualities plus a quality of wistfulness made me long to help May to develop into a surer, more independent person than the 'weak sister' she now seems, even apart from her disease. I believe that May also has the intelligence to be workable material in spite of the fact that she is two or three years behind the normal grade for her age in school, being only in the fifth grade, and in spite of the fact that one of the teachers at May's school showed surprise to our social worker that the worker should be helping the T's, implying strongly that they are a backward, worthless family. Nevertheless, to me May indicated practical intelligence in taking care of herself here at the hospital—in wanting to be neat and clean, and in the way she handled the bath tub and washcloth—and indicated intellectual curiosity and ability in doing number work for fun, in interestedly volunteering to repeat to me some of her geography lesson (one of her favorite subjects at school where she likes

almost everything), and in her enjoyment of being read aloud to.

We now have some picture of May and the kind of person she is. I shall now describe her disease, how it affected her, and how she was treated here in the hospital. Then I shall go on to her life at home which has had and will continue to have much to do with the ultimate effect of the disease upon our patient.

As we have said, chorea is a rather specialized form of rheumatic fever. The other two forms of rheumatic fever are polyarthritis and a type of carditis. The carditis usually comes with the polyarthritis, although it sometimes apparently occurs alone, and polyarthritis seems to be the most basic initial form of the disease or what I should call rheumatic fever proper. Rheumatic fever is a specific, infectious, noncontagious disease, the causative agent of which is not known, but is believed to be a filtrable virus. Predisposing agents are scarlet fever especially, and other forms of streptococcus infections including tonsillitis and sore throat, or, as a matter of fact, any upper respiratory infection, not necessarily streptococcic, that seems to weaken the body's resistance against the rheumatic fever agent. Predisposing factors are: being a girl (about twice as many girls as boys get rheumatic fever); being in middle years of childhood (5 to 15); being white; being in the temperate zone; and being poor, that is, fairly poor rather than desperately poor, as some people feel that dampness is the attribute of poverty that helps cause rheumatic fever. There is often more dampness in small, cheap houses than in crowded tenements.

The pathology of rheumatic fever seems to be the formation of a special kind of round lesion with a necrotic center and an infiltration of basophils and other cells around the outside. The lesions heal and become scar tissue. Frequently these lesions form in the heart, especially the valves, as Aschoff's bodies, where they cause heart damage. They form on the surface of the joints as nodules. Within the joint they stimulate a thick exudation and result in swollen, painful, inflamed joints.

There are several methods of onset of rheumatic fever. Sometimes the onset is abrupt with fever, prostration, and joint pains in one or several joints. The joint pains may be severe, with redness, swelling, heat, and pain—the typical signs of inflammation. Or the pains may be mild and fleeting, the joints remaining cold and normal in appearance. Another form of onset is that preceded by an upper respiratory infection, usually by two or three weeks. In another form, there is languor, fatigue, and perhaps slight fever several days before any joint signs.

The course of one attack in itself is usually not severe—but rarely does rheumatic fever itself cause death directly—and is self-limited. The pains usually travel around through several joints and

then, with the fever, disappear after several weeks. However, so common are recurrences that Dr. Gibson says that one should not speak of rheumatic fever as being 'cured,' but merely as 'arrested.' The dreaded complication of the first attack and more and still more of succeeding attacks is cardiac damage—of the valves, of the pericardium, and worst, of the myocardium. 60 to 70 per cent of rheumatic fever cases result in heart damage, or, to look at it from another viewpoint, 35 to 40 per cent of adult heart cases have a rheumatic fever basis, according to Dr. Gibson. The lack of sinus arrhythmia is a suspicious sign of heart involvement. The earliest common sign, however, is a soft, systolic murmur at the apex. After a few weeks or a few days, there may also be heard a midline tumbling diastolic murmur indicating definite mitral involvement, or a diastolic murmur over the sternum indicating definite mitral involvement of the aortic valve. There may be partial recovery from the heart damage or the end may be fatal after a long period of invalidism or after a short, rapid period going into heart failure.

The most basic part of the treatment of rheumatic fever is rest. One well-known doctor believes that any patient after an attack of rheumatic fever should stay in bed for three months. However, it is more generally felt that three weeks of bed rest after there is no fever—after the stopping of salicylates—is a safe enough margin, as heart damage, if it is going to occur, comes early in an attack or not at all until the next attack. Sometimes the heart condition demands digitalis and other heart drugs. The rheumatic fever itself is usually only treated by salicylates which may help the joint pains, although not so effectively as in arthritis.

Prophylaxis is of course most important for controlling a disease which is so little understood and so apt to bring about the permanent disability of heart damage. One of the obvious methods of prophylaxis, that of moving to the South where there is almost no rheumatic fever, is of course not practicable to most New Englanders. A certain amount of exposure to New England dampness is also unavoidable, but even the poorest usually can have some choice about not living in damp buildings. Nor can one completely avoid exposure to upper respiratory infections. Yet schools can do their part in sending home children with colds and parents can do their part in keeping these children away from other members of the family as much as possible, which, alas, is often not much, and in keeping their well children away from movies and other crowds when there are cold and la grippe epidemics. So important is the avoidance of exposure to colds that many doctors will keep a child who has recently had rheumatic fever, and has thus proven his susceptibility to the disease, out of school the first winter, when he is physically capable of attending school. Such children are sternly

warned to keep away from friends with colds and to go to bed the hour they feel a cold coming on.

I have described rheumatic fever proper at some length because, although chorea is a form of the disease with very different symptoms and immediate effect, Gibson says: * 'It should be emphasized that chorea owes its importance to its place in the rheumatic series; that without that association it would be an interesting but unimportant disease, and that not only its management during the active stage but the future care of the child should be conducted with a view to combating the rheumatic infection.'

Since chorea is a form of rheumatic fever, it probably has the same causative agent although some authorities have wondered if it is a special kind of this virus that attacks the central nervous system. Others wonder if it is a special kind of nervous system that is open to attack. Nobody knows. The disease occurs mostly between 5 and 13—in fact, it disappears with adolescence. Occasionally it occurs in pregnancy, often in those who had it in childhood.

The pathology is different from that of rheumatic fever—in fact, no actual pathology has ever been seen. It is believed, however, that brain inflammation occurs.

The onset is indefinite; the child is restless, inattentive, unceasingly irritable, and awkward. As the disease gets into full swing, three main headings of the disease are noted: mental changes, unco-ordinated movements, and muscular weakness. The mental changes include the irritability plus restlessness mentioned above. The child becomes inattentive to the point where he cannot concentrate, he becomes moody, unhappy, and easily tearful. The unco-ordinated movements affect every part of the body so that the patient cannot be really still except when asleep and cannot control the purposeful motions he does make, such as feeding himself. He grimaces with his face, makes clucking noises with his tongue, his speech becomes thick and slurred, or sometimes he cannot even speak. His arms are the most uncontrollable and he needs help in feeding. His gait is ataxic; sometimes he cannot walk. His very breathing becomes irregular. Not all patients have all of these symptoms, or all to such a great degree. The muscular weakness is likewise irregular and inconsistent. It is used diagnostically in the test of finding one grip at least to be very weak when the patient grips with each hand the hands of a second person.

The diagnosis of chorea is usually fairly easy. There is the history of irritability and absurd restlessness. Even if the case is not bad, if the patient is asked to sit still awhile he will soon start

* Brennemann, Joseph: Practice of Pediatrics; Vol. II, Chapter 19, Gibson, Stanley: Rheumatism and Chorea, Hagerstown, Md., Prior, 1940, p. 25.

making purposeless movements. The speech difficulty is also diagnostic.

There are two main treatments of chorea. The first is conservative and consists of bed rest with absolute quiet at first, no toys or other distractions. Gradually, as the child improves, he may be given things to play with and allowed some companionship. Throughout this time the patient is encouraged to sleep as much as possible. Phenobarbital is often given to promote sleep and quiet but Dr. Gibson does not believe that it shortens the course of the disease. Salicylates are also given to ward off heart damage and joint trouble, although they are probably not very necessary.

The other form of treatment is fever therapy. One method of inducing fever is by a drug, nembital, which, besides producing fever, makes the child quiet and dopey. All the actions, toxins, and dangers of this drug are not well understood as yet. Typhoid and paratyphoid vaccines are also used to produce fever, as are electric fever-producing machines. Fever therapy shortens the course of chorea greatly. However, it has certain inherent dangers, especially if the child is undernourished and anemic, has kidney trouble, or heart damage.

The most important part in treatment of chorea is concerned with the relation of this disease to the rest of the rheumatic fever cycle. Sometimes heart complications occur with chorea, although it is now believed that if rheumatic fever takes the form of chorea, in that particular attack it is less likely to take the arthritic and cardiac forms. However, once one has had chorea he is more likely to get other attacks of chorea or other forms of rheumatic fever and must therefore guard carefully against colds and must be checked by the doctor periodically for heart damage that might have come with some slight cold and attack of rheumatic fever that he hardly noticed.

Let us now return to May and the course that chorea took with her. She apparently had an attack two to three years ago when, according to the father, she was very nervous. The doctor gave some medicine for this and after seven to eight months the child was all right. In August, 1939, according to the father, the child, while at a fresh-air camp, was terrified by a thunderstorm and thereupon got another attack of her nervousness. According to Gibson, fear is now considered to precipitate an attack of chorea less often than formerly. Apparently May was very unhappy at the camp and missed home in spite of the fact that one of her sisters was there too. She did not join in with the other children at all but hung her head and kept by herself. After a week the camp sent her home. Whether the whole strain of this unhappy week plus the terror of the thunderstorm actually caused this second attack of

the disease, it is hard to say, but it well might have had an influence. At any rate the local medical doctor gave May some pink medicine (liquid phenobarbital is pink). She apparently improved a little, for after about two weeks' absence from school she resumed school and progressed satisfactorily in her work there.

Possibly pertinent facts in May's medical history before the onset of her disease are that she had scarlet fever some time in early childhood, the father rather vaguely believes, and that the year of her first attack of chorea her tonsils and adenoids were removed because 'she couldn't talk.' This might have been a sore throat predisposing to rheumatic fever.

Certain factors in her physical environment also probably contributed to her illness. In the first place May comes from a family belonging to the class I mentioned as most susceptible to rheumatic fever, the upper poor. Moreover, according to the hospital social worker, the T's live in a small frame house which, in spite of being fairly comfortable, with a good steam-heating system, is only one and one-half stories high—not very substantial sounding—and is located in the poor part of Boston near the railroad tracks, where it is probably flat, low, and fairly damp. Then May's living conditions are those from which most rheumatic fever comes. She was extremely thin. Some of this may have been due partly to the amount of energy expended in her constant choreic motions. However, her whole nutritional history was not too good. She was breast fed for two and one-half years. Even if she received the cod liver oil and orange juice during this time that her father claims she had, she was certainly lacking in iron, phosphorus, and Vitamin B that she should have been getting in cereal since six months and strained vegetables, eggs, and ground meats since nine months. May admitted that at home she received but few vegetables—macaroni seemed to be a mainstay of the T's diet. Thus May had not been built up nutritionally to be strong with good resistance against disease.

May, then, to continue with the account of her chorea, was admitted to the ward from the Out-Patient Department. At first she was wild with homesickness and raged and cried. Nor would she eat during this time and also, I think, because of her shame in not being able to feed herself. Finally, as her misery disappeared and her hunger grew, she began to eat well. Her misery was at first augmented by her being in a room alone, whereas at home she had always roomed with a sister and had other sisters and brothers about. In treating chorea isolation ensures ideal quiet. However, if the patient is made too miserable, he becomes so worked up that he more than loses the benefit of being alone. May seemed to improve more rapidly after she became happier, when she was given as

a roommate another little Italian bed patient in a happy, friendly, convalescent state. Depriving of toys is another hardship in the treatment of chorea that may make the child very unhappy. Fortunately, May loved to be read aloud to, and as the ward was not too busy when she was there, this form of amusement made up to her for any lack of playthings. However, she was not deprived of toys for very long, and gradually played with dolls, crayons, games, and finally made things with the 'play lady.'

Sleep as well as bed rest is one of the important factors in curing the chorea patient. We keep a chart of the actual time spent awake and asleep by such a patient. Although May never slept in the day more than during rest hour, she slept steadily from seven at night until breakfast time at six-thirty in the morning. The one and one-half grains of phenobarbital May received daily helped her relax. Important too was the nursing care she received. The darkening and cooling of her room and straightening of her bed for rest hour and the careful crumpling and tightening of her bed at night contributed directly to her sleeping well. More indirect influences were the calmness and pleasure May gained from being kept bathed and neat and curled and pretty by nurses who were friendly, talked to her, and seemed interested in her as they worked.

May thus illustrates the essential principle in the nursing care of the chorea patient of keeping that patient quiet and at the same time as contented as possible. The means varies with different patients—some are not as responsive to friendliness and personal attention and decoration as May but tact and imagination can usually find the key.

When May first arrived there was some question as to whether her heart had been involved, as a moderately loud systolic murmur that persisted with exercise was heard normally at first, and the visiting doctor later reported heart enlargement with a loud apical, systolic murmur. However, the electrocardiogram report said, 'No evidence of rheumatic fever,' and May showed sinus arrhythmia—her pulse slowed upon holding her breath—a sign that there is no heart damage. When she left it was generally considered that her heart was all right, the murmurs being some of those relatively insignificant ones sometimes heard in children, in this case possibly being due to May's malnutrition.

May was discharged 16 days after entering. Under the prescribed treatment of bed rest, no toys at first, phenobarbital, grains one and one-half, aspirin, grains 15 a day, high-vitamin, high-caloric diet—she really ate all her vegetables—and under the nursing care described above, May had gained four pounds and had improved greatly so that she could sit quietly and co-ordinate her movements, although she still talked with difficulty and slurred her words.

We have emphasized the importance of chorea as a form of rheumatic fever. What of May's prognosis in regard to further attacks of rheumatic fever with subsequent heart damage?

In spite of May's improvement during her stay at the hospital she was still under par—she was almost 30 per cent under weight according to the normal and she had not had sufficient rest by many weeks to clinch the end of her present attack of disease. The doctors here felt that more real rest was obligatory for her future welfare and requested the social worker to have May admitted to the Home of the Good Samaritan that specializes in the care of rheumatic fever children. The social worker had even arranged for the Boston Charities to pay the necessary \$5.00 a week to keep May there. However, May's family would not be persuaded to let her go there but insisted upon taking her home.

One feels that the same lack of intelligence that made May's family thus go against the advice of the doctors they had gone out of their way to seek (since they had not been content to keep the regular Boston doctors) would make them ill-fitted to contend with the problem of keeping rested and quiet a 12-year-old girl who can be quite stubborn and who is feeling well and will want to romp and play with her younger sister and be in upon what her older brother and sister are doing. One pictures the mother who has to do housework and cook for six people—and we know she is not intelligent enough to give them many vegetables and keep May well nourished—being too busy to keep May in bed and probably unconvinced as to why May, who now looks and seems well, should stay in bed anyway.

In a sense, the hospital has thus failed in carrying through its full program of treatment for May. Could May's family have been persuaded to let her go to the Home of the Good Samaritan by any further means such as the social worker's taking Mrs. T. to show her that institution? Or are the T's essentially unteachable? The T's are Italians and social workers find them the hardest to work with and to teach the customs and ways of living that work out best here in this new urban civilization, so different from their home country. The Italians tend to live within their own family walls and to refrain from meeting an outsider on common ground. Thus our social worker felt that the T's were holding something back from her in regard to their financial situation. Although they talked about it and the father, a laborer, said he had been out of work and on the W.P.A. for six weeks, and although the other son at home was also out of work, leaving some of the wages from another son who had joined a C.C.C. camp in Wyoming plus the W.P.A. wage as the only income, the social worker felt that the T's were not really worried about finances and possibly had some additional money

coming in. This feeling was supported by the fact that they had sought financial help in the past only for a tonsillectomy and incision of glands. This help came from the Catholic Charities; the family was not on the lists of any charities. In the T's yard there was, in good repair, an old truck and an automobile. This showed that there had once been at least a little capital in the family. One could say that maybe the T's had now really come to the end of all their money. I know the social worker felt that this was not true, for the financial arrangement relative to May's stay at the Good Samaritan did not seem to impress the T's a bit.

The factor that makes the Italians hardest of all to deal with is their emotions, which so quickly dominate them to the exclusion of reason. It's the natural emotional response for a mother to want to keep her sick child at home with her; but it is not facing facts. I have just been reading a novel called, *The Yearling*, wherein the hero, a boy of 12, finally sees that it is necessary according to the laws of existence that the deer he found as a newly-born fawn and nurtured and loved with all his heart be shot when it grew into a large, unmanageable buck that could not be kept from eating the young corn upon which the young hero and all his family must exist. In this novel the hero had to take this step into manhood himself. Some adults have never grown up enough to take this step and when they haven't, they and their children, their pathetic little Mays, must suffer directly and society indirectly. If the wrongs these adults commit are crass and patent enough, society can step in forcefully. Otherwise, having tried persuasion and failed, society can only hope that the next generation can be approached early and taught to mature."

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13

Insights from Nursing-Care Studies

FOR SEVERAL years a growing belief in the seemingly intangible elements of nursing has been in the process of development. When the nurse, student or graduate, begins to look beyond the routine nursing care to the individual needs of her patients, to observe them as varying personalities with problems, drives, and interests, and to make a plan for care and teaching for the patient and his family group, the results of good ward teaching are apparent.

Insight into a patient's true needs presents a tremendous challenge to the real nurse. She sees where she may begin to function, where she needs the assistance of other hospital and community workers, where she may hardly dare hope to extend her scope. Insight helps her adjust to the patient's level, and if her judgment is well developed, to give sound health instruction. Insight into many patients' problems gives professional poise, for it carries with it an understanding of nursing functions.

The heart of nursing is at the bedside of the individual. Ward instruction gives life blood to this heart. Hence sound ward teaching is basic to sound care of the patients.

In ward teaching, the patients are the subject matter for study. Books are a source of reference. Burton, in *Supervision and the Improvement of Teaching*, says: * "To many people subject matter means the material found in the textbooks, periodicals, or other printed sources. Another group . . . maintains that subject matter is best found anywhere except in books. To them subject matter is life. The truth of the matter probably is that subject matter is much more than can be found in books and a good deal less than all of life. . . ."

* Burton, W. H.: *Supervision and the Improvement of Teaching*, New York, D. Appleton and Co., 1924, p. 261.

The following insights obtained from several nursing-care studies show the use of significant information in the improvement of nursing care. They demonstrate the tremendous interest value which these individuals—our patients—afford us. Each example has been analyzed to show the student's insights into the patient's needs.

I. Left Radical Mastectomy for Papillary Cystadenomatosis
Student's Insights into Patient's Needs

1. Appreciation of the effect of worry, fear, and restlessness on the operative patient.
2. Importance of adequate explanation before procedures and treatments are given.
3. Consideration of patient's location in the ward in relation to other patients.
4. Contribution of social worker in alleviating worry caused by problems in the home.
5. Importance of teaching care of wound and arranging for return clinic visit.
6. Understanding of the relationship between early diagnosis and prognosis in cancer.
7. Appreciation of the financial cost of illness and hospitalization to the patient and her family.
8. Need of instructing patient in specific details of caring for wound, such as the method of cleansing, equipment required, disposition of soiled dressings.
9. Appreciation of the hospital's interest in return clinic visits and in her general health.

"Since worry, fear, and restlessness predispose to postoperative shock, it is especially important to reassure the patient and build up her confidence in the surgeon's skill and the resources of the hospital. Removal of repressed fear is as important as calming a nervous, excited patient. The effects of fear may interfere with the patient's heart, influencing the induction of anesthesia and the respirations. There may be respiratory obstruction, cyanosis, increased blood and pulse pressure, and a loss of body heat under the anesthetic because of repressed or active fear. A calm attitude, a frank explanation of the procedure with confident assurances of a successful outcome may be all that is necessary. If the patient is on the ward before operation her bed should be placed near that of a patient who is making a satisfactory recovery rather than near a seri-

ously ill or noisy patient. If home problems, such as the care of the family, hospital expenditures, absence from work, fear of losing a job, etc., are causing the patient to worry, a social worker may be able to help, thus relieving the patient's mind. . . .

When Mrs. J. came into the Female Surgical Clinic on August 30, the wound was healing well except for a superficial slough at the lateral aspect. The arm motion was good and there was slight tenderness in the axilla without induration. The wound was thoroughly debrided and a dry sterile dressing applied. Mrs. J. was asked to wash the wound with soap and water once a day and to return in one week. In doing the dressing at home she boiled the soap and water solution in a bowl and let it cool sufficiently so that she could use it. She also boiled two tweezers and used them in handling the sterile gauze which she bought at the drug store. This gauze becomes rather expensive when there are many dressings to be done at home, but Mrs. J. washed and boiled the less soiled pieces and used them for the outer dressing. Many patients in doing their dressings at home tear up old pieces of linen, wash them, dry them in the sun if possible, iron them with a hot iron, and keep them in a clean, ironed pillow case until used as dressings. Mrs. J., however, preferred to use the sterile gauze, which is very good if the patient can afford it. . . .

When Mrs. J. returned on September 23, the wound looked much better and was almost entirely healed. A dry sterile dressing was applied and she was asked to return in one week. This was the last time I saw her. Her prognosis is guarded, for although malignancy was not definitely proved, one cannot be certain that it might not appear in some other part of the body. Mrs. J. has been advised about the importance of seeing a doctor when she first realizes that something is wrong and about having a bi-yearly physical examination in spite of apparent good health. If everyone could realize the importance of receiving medical attention early, there would be fewer deaths from cancer. Cancer of the breast is often unnoticed because it is painless and the patient does not think to feel for a lump. Women should be told to feel the breast tissue about every six weeks—eight times a year. If a lump is felt, expert advice should be sought at once. To examine the breast, the tissues should be pressed gently with the palm of the hand against the chest wall. In this manner a lump can be easily felt. Cancer of the breast can be cured when it is in one spot only. When the growth has spread to the armpit, the chances for cure are diminished. With

the further spread into the glands of the neck, the possibility of cure is remote, and when the metastases have reached the chest or bones, cure is impossible. Results show that when operation is performed in the early stages of the disease, 70 per cent of the patients are still alive and well at the end of five years. If the disease is far advanced, 96 per cent will not be alive at the end of five years. A periodic physical examination twice, or at least once a year, by a physician who is familiar with the predisposing causes and the early signs of cancer, will do much to protect an individual against this disease. . . .

In conclusion it is interesting to note Mrs. J.'s hospital expenses:

16 days' hospital care	\$55.00 (\$24 a week)
Operating room	10.00
X-rays:	
Chest	4.00
Skull	5.00
Spine	3.00
Out-patient visits	3.75
Two pre-operative, five postoperative	
First visit \$0.75, others \$0.50	
Total	\$80.75

Mrs. J. was able to pay all of her bills. Of course in addition to these expenses she had her transportation costs to and from the clinic visits, and the cost of her sterile gauze."

II. *Otitis Media, Pneumonia, Diarrhea and Vomiting, Abscess on Back*

Student's Insights into Patient's Needs

1. Interest in child as an individual and other people's reactions to her.
2. Appreciation of the family background as a handicap in child's future health and development.
3. Importance of isolation for sick children in the home.
4. Appreciation of the public health aspects of the illness through finding the cause of the intestinal upset.
5. Need of immunization of young children against smallpox, diphtheria, and whooping cough.
6. Need for skillful nursing care in meeting physical needs of patient and dispatching treatments or special comfort measures.

7. Awareness of need for quick, skillful care to avoid tiring or irritating patient.

8. Function in observing and interpreting observations of patient's condition and quickly relieving distress.

9. Importance of accurate recording of patient's symptoms, fluid intake and output, and character of stools.

10. Reason for administering the sulfonamides and awareness of toxic symptoms and prescribed procedure in adaptation to patient's needs.

11. Awareness of effect of Dakin's solution on the skin and need of adequate protection.

12. Necessity of avoiding secondary infections following an acute illness.

13. Need of developing independence in child after concentrated attention during a critical illness by letting child feed herself.

14. Attention to habit training of bowels and bladder.

15. Need of objective attitude toward accidents during habit training.

"I saw her first almost two months ago at the beginning of her illness. Since then, I have seen or taken care of her nearly every day. I have been able to watch closely her loss and gain. I have also grown to love her quiet mannerisms and watch her become less of a baby and more of a tiny little girl since her hospital stay.

Introduction? She is now sixteen months old with very light, fine-textured, curly hair. She is quite small, almost 'petite,' with a round, attractive face and an adorable, wistful expression. When she smiles it disappears and one of complete trust and sincerity takes its place. She completely wins everyone at first sight. As she has been here since October, 1940, she is quite well-known and loved by nurses, doctors, and daily ward visitors. I have noticed too that those seeing her for the first time like her at once. However, for all the attention, she seems unspoiled. She is simply an adorable child who has been extremely ill.

Mary comes from a Protestant family near Boston. She lives with her mother, sister, age eight, brother, aged four, and twin brother. Her father and mother have separated and they are supported by the Family Welfare Society. I have met the mother on several occasions and felt that she is apt to be a slack, careless person. Undoubtedly the child's condition on admission is a reflection of the home environment. However, it is possible that the financial

situation made the mother put off having the doctor until Mary was so ill that it became an absolute necessity. Mary had never been sick before so her mother didn't know how she would appear in an acute illness.

When she first came on the ward, she was described as 'pale, thin, with marked dehydration; limp and drowsy with eyes half closed and a sweet breath; both ear-drums red and bulging; teeth good, but tongue dry and crusted; superficial ulcerations on her tongue; small anterior fontanelle open; genitalia dirty, and nose dry and crusted.'

These signs and symptoms not only revealed the seriousness of her illness, but also pointed out the necessity for immediate and skilled nursing care.

Before outlining the nursing care that Mary received, let me tell a little of her ailments and medical treatments. Her medical history previous to this first hospital admission was, briefly, a visit a week before to her home by the city doctor. He came to see Mary's twin brother who had a head cold. While there, he very wisely examined the other children and found Mary's right ear-drum reddened with evidence of a slight inflammation also in her left ear. He ordered warm ear irrigations every three hours. These were done, but while her brother got better, Mary became much worse. Two days later she began vomiting and had diarrhea. The vomitus, without bile or blood, was the color of her feedings. Her stools were brownish green, loose, and from twelve to fifteen a day. Tincture of paregoric, an opium preparation with a constipating effect, made the stools much firmer and decreased frequency. However, vomiting continued. At this same time the other younger children also had vomiting and diarrhea which lasted only one day. This indicated the importance of isolating sick children, particularly in the home. No one knew the cause of the vomiting and diarrhea in Mary's home. It could have been food, intestinal cold, or, since only the younger children had it, it might have been the milk.

She had always been a healthy little girl. At birth she weighed five pounds while her twin brother weighed six and a half pounds. She has been the weaker of the twins, but never sickly nor more susceptible to colds and infections. As a matter of fact, she has had only two or three head colds in her life. She has had no prophylaxis against smallpox, diphtheria, or whooping cough. As an infant she was breast fed for one month and since that time has

received whole boiled milk. The mother's health was good during pregnancy, and the neonatal period was uneventful.

Here she is with no previous predisposing factors or hereditary weaknesses but with the following diagnoses: diarrhea, otitis media, dehydration, and acidosis. . . .

In view of the foregoing facts, nursing care was the chief consideration. Her routine care was a daily bath, always necessary with children since they are so often incontinent. Mary needed local care to the genitalia even more often than at the bath since her genitalia were irritated from lack of care. Hence we washed her well with soap and water, rinsed and dried the parts frequently.

Mary cried a great deal when she first came in, especially when we disturbed her. . . . Her hair needed special attention and very careful combing, since it was so fine and curly.

Her mouth was dry and caked with mucus. This we swabbed out, giving special care to her teeth and tongue. Since she was unable to rinse her mouth, she was turned on her side and small amounts of water were used to cleanse it. Then mineral oil was used in her mouth and on her tongue to keep the area moist and free from cracking. This was repeated frequently.

Mary had a small reddened area on her buttocks when she was admitted and we kept this clean and dressed with aristol powder, which has a drying effect. Since her skin was dehydrated, special skin care with alcohol was given, and she was turned frequently. She was kept off her back at all times because of the area and the slowly healing abscess.

Of course all this required quick and thorough workmanship because she was so ill and cried when moved. However, there was necessity for a great deal of tact and careful handling to perform the various treatments such as hypodermoclysis, intravenous infusion, flaxseed poultices, myringotomy, hypodermic medications and operations, and oxygen by using the oxygen tent. Although Mary was too ill to resist most of this treatment, she must have felt as though she were having a disturbing dream, for she had never known illness before.

In caring for children, especially ill ones who require such close observation, the nurse has a double responsibility. She has to sense discomfort and pain, and relieve it. She has to watch closely for symptoms that a child would not mention. She has to be genuinely sympathetic and kind, to allay any fears that a child might have arising from a strange environment and unfamiliar routines,

which would thwart rest. She needs to chart accurately and completely all the important things about the child, including intake and output, temperature, and progress of condition. In Mary's case, the amounts of intake and vomitus were important; for from this record the doctors prescribed intravenous fluids and when vomiting ceased said that she could start taking foods by mouth. The bowel movements were described and the amount and frequency charted. Her reaction to morphia and oxygen needed careful watching and flaxseed poultices were applied cautiously to avoid burning.

Mary was getting sulfapyridine and sulfathiazole, which are toxic and may cause vomiting. This required careful observations and reporting so that the dose might be repeated if necessary. . . .

Her ears were inspected and drainage reported accurately. . . .

At present Mary's nursing care is much less complicated but as important. She has her bath and general hygiene care as before. Now, however, to the abscess she has a Dakin's dressing that is changed three times a day. Not only must aseptic technic be carried out due to the high incidence of secondary infection in an open wound, but also the skin must be carefully protected to prevent destruction of the surrounding tissue by Dakin's solution, which contains chlorine.

Since Mary's resistance is quite low and she is sitting up in a chair, we need to dress her warmly and avoid drafts.

As she is old enough, we are now trying to teach Mary to feed herself. When left alone with her tray, she only plays.

She is progressing very nicely with her walking, but still needs support; as her strength returns, she will be able to walk alone.

One especial problem with Mary is the matter of incontinence of urine and stools in her bed and clothes. We are training her to have regular times to use the 'potty' chair which include before and after meals and usually twice in between. Each time she is put on, the reason for her being there is explained and although she doesn't talk, I feel she understands what is being said. Then when an 'accident' does occur, she is told that she isn't supposed to do that, although not shamed or scolded, and then set on the chair.

Such training seems effective and only requires patience in its use. In the future we will need her mother's full co-operation. This, I feel, will be hard to get since the mother seems lazy and uninterested in matters of hygiene and training. And too, she says that Mary is much too young to be taught the importance of habit training and hygiene. . . .

I feel that with the good prognosis that Mary has, she will be a lovely, attractive person. The only thing she appears to lack is a mother's attentive and intelligent care.

I am very fond of Mary and wish very much that she might have a better regulated home where she could receive the attention and training she deserves."

III. *Hodgkin's Disease*

Student's Insights into Patient's Needs

1. Helping the patient face a fatal illness.
2. Necessity of reassuring and encouraging the patient in small things.
3. Need of assuring the patient that everything possible is being done.
4. Significance of patient's illness to the family.
5. Need of relieving the patient of as much worry as possible.
6. Appreciation of Mr. R.'s love and pride in his son and value of his visits to the patient's morale.
7. Necessity of securing the family's co-operation in his care by arranging for them to talk with the doctor and learn of his actual condition so they may understand his needs.

"Mr. R.'s mental state was a problem to us. When he entered the hospital he was very apprehensive about his condition, looking at us with terror-stricken eyes, and asking in his broken English how he was getting along. As the days passed and he became progressively worse, after one of his severe coughing spells when he was all choked up, he fell back on his pillows moaning and groaning that he wasn't getting any better. Occasionally he would cry and with dry sobs say that he would never recover. This presented a great challenge to make him feel that all the resources of our hospital were being used to aid his improvement, that the doctors and nurses were doing everything in their power to help him. Appealing to his love for his family, one was able to quiet him by saying that he would never want his wife or son to realize that he would give up so easily. Reassuring him was difficult and sometimes was accomplished best not by talking, but by doing little things for him to make him more comfortable. He appreciated all kindnesses.

Tied up with his fears that he would never recover was the inevitable problem of finances and what it would mean to his son if

he should not recover. Mr. R. had been a shoe worker employed by the — Shoe Company in D. for many years. His job consisted in ironing leather on the finished shoes, in return for which he received a meager income. Because he was ambitious for his son, he in some way contrived the means to send him to B. College. His becoming an invalid would mean that his son would have to leave college, obtain a job, and provide for them. This would be a great disappointment to everyone. It pleased the father to speak admiringly of his son after his visits. He came to see him frequently, sitting by the bedside and giving the sick man support."

IV. *Lung Abscess*

Student's Insights into Patient's Needs

1. Awareness of patient's need to discuss her physical condition and family, and importance of student stimulating "this discussion."
2. Patient's adjustment to illness with healthy attitude toward physical disability, and sincere confidence in hospital, medical, and nursing staff.
3. Importance of arranging special visiting hour for husband, and recognizing his contribution in stimulating the patient's recovery.
4. Influence of visitors with flowers and other tokens of affection, in satisfying patient's need for attention.
5. Importance of spiritual guidance.
6. Arranging postural drainage in relation to other activities, i.e., bath, meals, and at a time when it can be followed immediately by a rest period.
7. Adequate explanation of all treatments, particularly postural drainage and bronchoscopy.
8. Placing patient in a relatively comfortable position for postural drainage.
9. Recognition of comfort measures such as chest binder, saline gargles and aspergum after bronchoscopy; frequent changing of linen, arrangement of pillows to ensure relaxation, and use of cardiac table.
10. Individual adaptations for comfort: type and weight of bed linen, arrangement of lighting and ventilation of room, use of catheter instead of customary rectal tube.
11. Teaching health measures and prevention.
12. Encouraging patient to call on public health nurse to supervise care in her home after discharge from the hospital.

"My first acquaintance with Mrs. C., a 38-year-old Italian woman, began when she arrived on Ward —. She was brought from S. Hospital on a truck piled high with pillows supported by a chair, in order that she might maintain an upright position. She appeared to be in a state of extreme discomfort, finding it very difficult to breathe and to talk without effort. Her face was flushed and she was perspiring profusely.

Mrs. C. is a heavy, obese woman for her height. Her dark hair is combed straight back from her face; her eyes are brown and friendly. She is reserved and lets the other person take the lead in conversation. Several nights while working on relief I had the opportunity of making Mrs. C. comfortable for the night. At this time, after darkness had fallen and the hour for confidences, so to speak, had arrived, Mrs. C. seemed quite willing to converse and talked about herself and her family. She seemed to accept her illness without apprehension, with the attitude of its being but one more thing to endure and that soon she would be better. She never questioned her treatment but had the utmost confidence in her doctors and nurses and did all she could to co-operate with their orders. Much of the time Mrs. C. was much too ill to answer except with 'yes' or 'no'; often she would respond in her typical manner, 'All right, nurse, whatever you say,' which seemed to give an insight into her attitude as a patient.

Her husband visits her faithfully every noon. He cannot come at night because he is required to be at his place of business. They own a dine-and-dance place in V., called D., which is fairly successful and nets them a satisfactory income. Financially their worries are not great; they have sufficient money on which to live. Mrs. C.'s oldest son, age 17, who graduated from high school, is running the household for the time being; he cleans, makes the beds, and prepares the meals. Her other boy is 16 and is still in high school. Both Mr. and Mrs. C. assume a cheerful attitude when together and attempt to encourage each other. I have seen Mrs. C. on her sickest days smile valiantly during her husband's visit and do her best to keep up while he was there so he would not worry so much.

Both Mr. and Mrs. C. show good common sense and more than average intelligence. Mrs. C.'s friends and relatives are well-dressed, intelligent-appearing people. A devout Catholic, Mrs. C. finds comfort in her religion at this time and enjoys the visits of the parish priests.

Mrs. C. is diagnosed as having a lung abscess. . . . Postural

drainage was prescribed for Mrs. C. This treatment was explained to the patient with detailed directions about procuring for her the most effective position. In postural drainage, it is necessary to place the head and chest of the patient in a position dependent to the rest of the trunk and thereby attempting to drain the abscess through the bronchus. It was discovered that she could raise the most sputum by lying across the bed and by resting her head and arm on a low footstool beside the bed, with the affected side in the lower position. A sputum cup and mouth wipes were within reach and the nurse was at hand to reassure her and observe her general reaction to the treatment. This was done for Mrs. C. five times a day, at nine, twelve, three, six, and nine. It helped somewhat to increase the amount of sputum raised but there was not adequate drainage. Thus a bronchoscopy was done in an attempt to enlarge the opening of the bronchus through which the pus comes, permitting freer drainage. This treatment produced little improvement. Mrs. C. appeared very tired after postural drainage and she would perspire profusely and continue to cough for some time. A tight chest binder helped to make breathing a bit easier but following the treatment she only wanted to rest. She accepted the bronchoscopy as another attempt at relief. Her throat was extremely sore afterwards; this pain was somewhat relieved by warm saline gargles and aspergum. . . .

Mrs. C. presented relatively few problems in nursing care. Her comfort was the chief object to keep in mind. Because of her profuse perspiring her draw sheet and gown required frequent changing. Being a stout person and having her bed maintained in an upright position caused many wrinkles in the draw sheet. Changing and tightening the sheet, and pulling up the mattress which slipped down easily even though her knees were elevated slightly, were small comfort measures which helped to make Mrs. C. more relaxed. The several pillows at her back and head required frequent turning and changing of position. Loops of bandage tied onto the springs of the bed kept the pillows in place. Small pillows under each arm also make Mrs. C. more comfortable. At times she had a rubber air-ring covered with soft cotton sheeting underneath her buttocks; at other times she felt better without it. Throughout the day she preferred to have just a sheet and spread on the bed with a blanket over her feet at night. Placing a pillow on the cardiac table upon which she could lean occasionally was welcome to her but most of the time she dozed or relaxed best by leaning

back against her nest of pillows. . . . Mrs. C. needed frequent mouth care and she liked the taste of the alkaline mouthwash best of all. . . .

Keeping the room cool and having a good circulation of air were important points in Mrs. C.'s comfort. She liked to have the blinds drawn throughout the sunny part of the day as this darkened the room and permitted occasional naps.

Mrs. C.'s bowels caused her much discomfort and trouble. Neither mineral oil nor milk of magnesia seemed to give her relief. Enemata were given to relieve her distress. On the morning of her operation an impaction was removed by the doctor, following which she received an enema and nupercainal ointment about the anus. Because of the pain in her rectum, a catheter was used instead of an enema tube. . . .

Although she was not of a demanding nature, Mrs. C. did enjoy little visits from the nurses and liked to feel that they enjoyed talking to her for a few minutes. Small things pleased her. She loved flowers and the beautiful bouquets brought by friends were a pleasure. She enjoyed smelling the individual blossoms. I saw Mrs. C. after her operation. She was pleasantly located in a bright, cheerful room and seemed to be progressing nicely. She realized that her progress would be slow and that when she goes home rest must play an important part in her life. I cautioned her to avoid exposing herself to anyone with an upper respiratory infection, not to mix with crowds, or lower her resistance by overfatigue. She should relax at home and avoid worries. She said that probably her son would continue to take care of the house until she would be able to do it and that her husband would be near by at all times, since their home is close to his place of business. I reminded her that there was a public health nurse in V. and she recalled that she had previously had the nurse call to see her husband when he was ill. She seemed pleased to think that she too could receive visits from the visiting nurse and commented on her pleasant, capable manner and felt the nurse would take good care of her."

V. Hypopituitarism

Student's Insights into Patient's Needs.

1. Observation of patient's facial expressions, attitudes, and general reactions to physical immaturity.

2. Understanding of the family situation, patient's position in family and social history.

3. Appreciation of Annie as an individual.
4. Importance of oreton to patient, and method of securing supply for use.
5. Patient's need for dietary instruction and planning for Annie and her mother to prepare wholesome meals.
6. Necessity of utilizing various specialists to plan for Annie's future and her family's need.
7. Contribution of Family Welfare Society, the dietary department, social service, and the medical dispensary in the development of a working plan for the patient and her family.
8. Importance of providing a measure of independence for Annie through some financial security.

"Annie B. is the cheerful, smiling little Italian girl who slips quietly into Female Medical Clinic three times a week for her hormone injection. Although she is twenty years old, one would take her at first glance for a child of ten. Further scrutiny, however, reveals a maturity one would not find in the face of a child, something almost indescribable, but probably the result of years of patient suffering and desperate longing to be like other girls. When talking to a social worker at one time, Annie said, 'Every night I pray to God, Miss W., that I will grow and that he will put the right ideas into the doctors' heads so they will give me the things to make me grow.' This probably accounts for her grave eyes and oldish face which is suddenly transformed by a cheerful smile whenever she speaks.

Her voice is somewhat childish, as are also some of the things she says. Her intelligence is not that of the average girl of twenty, but for a person in her circumstances she is intelligent. Her education consisted of graduation from the N. Hospital School in C., which has only eight grades. She returned to her home after that and attempted high school, but gave it up because she found it too difficult. . . . She stayed at home with her younger sisters. She has two girl friends now, however, who are 15 and 25 and they have undoubtedly helped her a great deal. Annie's special interest is sewing. Her religion is Roman Catholic. . . .

Every Monday, Wednesday and Friday, Annie comes in to the dispensary and has oreton injected into the deltoid muscle of her arm. This preparation is quite expensive, but as Annie is a member of Dr. F.'s Clinic she receives this medication from his laboratory free of charge.

Since Annie has been getting oreton, she has improved remarkably. Her spells of depression are fewer and her general outlook on life is a great deal brighter. She is less self-conscious, more independent and self-reliant, as is evidenced by the fact that when she first came to clinic her mother always came with her and now she makes the trip alone.

Annie was referred to Social Service when her mother found the expense of coming into clinic too much for her husband's meager salary which is about \$20. She was already known to Social Service as the family had needed help at other times. Both her mother and father had been seen in the clinic at some time and her sister Kathryn, who is three, has been in well-baby clinic and referred to the habit clinic on B. Street, as her main difficulty was the fact that she was spoiled. There are seven other children besides Annie who is the oldest. They are a very well-mannered family, appreciative and co-operative. They live in a three room apartment on the fourth floor of a tenement house, which is necessarily cramped, but is, nevertheless, clean and neat. Their mother is an excellent housewife and does her best to provide for her family on their meager income. Recently the two older boys have begun to earn money and this has somewhat lessened the burden.

When Annie was questioned about her diet, it was found to be inadequate. Her breakfast usually consisted of bread and butter and sometimes an orange. Lunch was a sandwich or soup and some milk. Supper always included a cheese and spaghetti dish, vegetables, and tea, coffee, or cocoa. There was seldom a dessert as Annie's father doesn't care for desserts. In an effort to improve her diet, a student dietitian was sent to the home to talk to Mrs. C. As money was scarce, there wasn't much meat and Annie did not care for fish. In order to further Annie's interest in her diet, the social worker sent Annie pamphlets of recipes and the dietitian showed her and her mother about preparing some of them. Annie likes to cook and has become quite interested, improving her diet a good deal. The Family Welfare Society agreed to give the family \$2.00 a week for food in order to ensure a more adequate diet.

Annie is closely attached to her mother, but her younger sister doesn't seem to understand her. In size she comes between her eight- and ten-year-old sisters. Her small stature undoubtedly seems strange to them and would account for their attitude. They never play games together and Annie usually spends the evening sewing. The social worker entered her in a nightly sewing class at Central

Square Center. She enjoyed this and did very nice needlework. She wanted desperately to earn some money so that she wouldn't have to be so dependent upon her parents. She dislikes very much to ask them for money as she feels they just can't afford to give it to her. The social worker got Annie a job in the library at T. . . . She is also learning shorthand and typing and doing quite well. Annie hopes to get a permanent job which will pay her more money. A girl friend who is a lawyer is helping her, and Annie feels quite certain that she will have a job before long.

At present Annie is continuing her N.Y.A. work; Social Service is providing her with train fare for transportation to and from the hospital.

Annie's prognosis is excellent. She has grown two inches since the treatment of oreton was started, and although she will probably never grow much taller, she is gradually developing, feels much better and stronger, and has a much healthier mental attitude. At present, there is no reason why Annie should not in time feel perfectly well and have a job which will pay her enough to make her feel independent."

VI. *Multiple Sclerosis*

Student's Insights into Patient's Needs.

1. Recognition of the need for mental therapy.
2. Attempt to overcome patient's inability to void with practical measures, and establishment of normal regimen.
3. Consideration of patient's location in the ward in relation to placement near patient who would exert a good influence.
4. Need to stimulate patient to do things for self.
5. Need to plan for physical care.
6. Arranging for comfort measures to relieve pressure from sensitive areas of extremities.
7. Appreciation of patient's need for encouragement, and praise in small accomplishments.
8. Contribution of social worker in planning for sanitarium care and ultimate return to her own home.

"There is no favorable prognosis for a patient with this disease. She will never again be a well person although her life will not be necessarily shortened by her disease. The only treatment is to keep her as independent as possible without allowing her to become over-tired. Mental therapy plays a large part here as these patients

become easily discouraged and mentally depressed or else they go on to the other extreme and become perfectly satisfied and happy with their invalid state, becoming an increasing burden on their families.

Alice was first on complete bed rest, forced fluids, and encouragement to void. These sound simple enough in themselves, but they presented difficulties to the patient. Alice was quite content to lie back and be waited on and it took a great deal of prodding and encouragement to get her to do things for herself. On her arrival she couldn't void and she didn't try. However, she was soon put on forced fluids and three-hourly bed-pan regimen with all stimuli present. Before very long she had started to void and when she was discharged she was having no further difficulty.

On admission she was being fed, washed, and her teeth brushed for her. Fortunately there was a patient in the same room who was blind but took pride in doing everything for herself. This exhibition of independence had an excellent effect on Alice, and she too, with great encouragement, began to make herself independent.

Supportive nursing care consisted of care of the nails as Alice did not have sufficient control over her own fingers to clean her nails; care of the hair which was very thin and inclined to be excessively oily as often happens with bedridden patients necessitating a shampoo; inspection of the mouth, as her efforts at brushing her teeth were not always adequate. . . . Diversion was more of a problem, as the dimness of her sight did not permit either reading or writing.

Alice's heels were extremely sensitive and the weight of her feet seemed to bother her considerably, so some heel rings were made of cotton and bandage to take the pressure off these areas. Later a pillow under her ankles was substituted. This lifted her feet entirely off the bed and shifted the weight onto her lower legs. This seemed to make a great deal of difference in her comfort.

It was fun to see Alice become more independent with encouragement and praise. Her lack of independence when she entered was a challenge and I believe that she gained a great deal during the short period that she was under our care. She has now been discharged to D. Sanitarium and I believe her relation with other chronic invalids should help her to see where she can make herself more independent and gain confidence in herself.

Ultimately we hope she can return home better able to face her disease which she fully understands at the present time, and be less of a care to her mother who is the only one at home who can take care of her. The social worker has become interested in her and

is doing a great deal to help her meet this adjustment. It is a difficult adjustment for any young person to meet and I think Alice is doing well under the circumstances. . . . I would be very interested in following her in the years to come to see how things will work out for her. Her church and her friends are all very much interested and I believe she will always be fairly well cared for."

VII. *Lymphedema with Ulceration, Large Scrotal Hernia, Bilateral Arteriosclerosis of Extremities, Senile Psychosis*

Student's Insights into Patient's Needs.

1. Appreciation and understanding of senility and its effects on Mr. H.
2. Importance of considering and making special allowances for physical and mental handicaps in daily care.
3. Attempt to maintain some semblance of patient's normal routine by seeing that he had a chance to look at the daily paper.
4. Ensuring an adequate dietary intake by planning to feed the patient.
5. Meeting individual needs by giving special mouth and back care.
6. Consideration of comfort measures such as a smooth well-made bed and frequent changes of linen to ensure a non-irritating environment for his sensitive skin.
7. Awareness of teaching responsibility and limitations through Mr. H.'s inability to comprehend.
8. Responsibility for assisting patient to give self-confidence despite handicaps.
9. Clever arrangement for encouragement of patient by caring for his inlying catheter and permitting him to sit in a chair.
10. Need of a plan to care for patient in the future and insight into social planning for the family.
11. Analysis of home situation with possibility of family caring for the patient.

"In this condition (senility) there is a progressive weakening of the faculties and a resulting degeneration of the brain due to poor blood supply and consequent atrophy and loss of those brain cells so important for higher mental functions.

Everything in the patient's life becomes purposeless. He appears disturbed, awkward, dawdling, and not infrequently he confuses the past with the present or vice versa. Also there are several types of

characteristics present in senility. No one should resent or criticize such a patient for they are not as alert as others to things occurring in their environment.

This patient seems to understand everything that goes on about him but he does not retain events in a clear manner. What appears to be perfectly clear and well comprehended at the present is forgotten in a short time. It is difficult to talk with him because of a natural speech defect, absence of teeth, and the residual effects of an old 'shock' which produced a hemiplegia of the left side at that time. This condition gradually cleared up but never entirely from the facial muscles.

Physically Mr. H. shows the common signs of old age. His senses are greatly diminished and movements are obviously awkward and unsteady. His skin is very dry, appears thin and very loose and wrinkled. . . .

About all that remains of interest to Mr. H. is his newspaper. I never saw him read it much but if by any chance the paper boy happened to miss him, he would become quite upset and tearful until one was secured for him. He used to scrutinize the entire paper minutely and no doubt he took great interest in the set-up of the paper and the various pictures which his work has helped to produce and improve during a lifetime of service.

Usually Mr. H. had to be helped in eating. He never said anything about the food but always ate everything without comment. However, when asked if he enjoyed a particular meal or some special dish he would seem to take on a new appearance and say, 'Good.' When, for some special reason, a meal was delayed, he would look around at the others eating and say, 'Don't I get any breakfast today?' Hence it would appear that he still had an interest in his eating, which so commonly is diminished to the point where malnutrition is marked and dangerous to these patients. . . .

The routine nursing care that this patient needed was far greater than is common in many cases, due to his greater disabilities. Feeding was best done by a nurse. His motions were tremulous and he was quite apt to spill anything that he tried to eat himself. This not only made an untidy bed but as the patient seldom talked and would not ask for more than was brought on his tray, he might have been hungry at times.

Mouth care was not any great problem because the patient had no teeth. Following each meal it was a simple matter to take a cupful of mouthwash and several swabs made of absorbent cotton

applied to the ends of small wooden sticks. Usually, about once a day, a larger amount of gauze wrapped about a throat stick would provide ample equipment for giving a little deeper massage to the buccal surfaces. This kept the tongue in good condition and prevented it from becoming excessively dehydrated, with the resultant formation of cracks, fissures, etc. . . .

Back care had to be carried out faithfully due to the thin, devitalized, wrinkled skin and the more or less frequent soilage and dampness to which he was exposed. Care was taken to massage the back well and deeply over the underlying bones and tissues to ensure the best possible amount of stimulation for supplying blood to the part. Rubbing was done until the skin was perfectly dry and then dusted lightly with talcum. This not only made the patient feel better, but also reduced friction between the skin and the bed linen. Sometimes it is noticed that the skin is hypersensitive to hospital linens and powdering will reduce the friction so that the reactions are not so severe. Sometimes, too, if the linen is pressed in wrinkles, the creases can be so arranged on the bed that they do not come where the greatest amount of pressure from the body will be placed directly over them.

Very little was accomplished in the way of teaching this patient. I tried to have him call for the bedpan when he needed it, but even this simple task was too much for him and he never could be made to understand just what it was for or how to use it. Consequently, as we all became better acquainted with the patient, we realized that we not only had to care for him, but also to think for him.

When the patient got out of bed, we had to provide some means of maintaining drainage from his catheter. This was easily done by placing the end of the catheter in a small bottle which was fastened around his neck. The bottom of the bottle was fastened to his leg to minimize the danger of spilling the contents. The bathrobe was then buttoned around him neatly and he was able to make a presentable appearance on the ward with the other patients. Another chair was drawn up in front of him and pillows placed on it. This provided a satisfactory means of elevating his ulcerated leg and relieved the patient from the constant monotony of lying in bed the entire time. It also lessened the danger of pulmonary involvement which is so common in the more elderly bedridden patient. . . .

Somebody needs to assume the responsibility of looking after him in the future. Care must be taken to supervise his diet, his activity,

and care for many small needs which are of vital importance and might be overlooked.

If cleanliness is not maintained, his skin will break down and produce a worse condition than he now has. If allowed to hobble about and is unassisted, he is apt to fall and injure himself, necessitating more expensive and painful treatment than he has been subjected to so far. Little readjustment to society is needed, for he no longer recognizes it. The whole situation seems to be one of total dependence on some person or society.

This care could be given in the home if it were possible. The rooms should be on the same floor and some person assigned and instructed in his case. The patient's home is a two-story frame building, and he would have to be carried up and down the stairs, and the danger of falling would always be present both for the patient and for the person assisting him at the time.

Furthermore, it would take a person with more than usual ability, patience, and physical endurance to care for a person in the condition which this patient now finds himself. He doesn't appear to realize that he is incontinent or different from other people in any way, aside from his inability to get about. Unless it were arranged for two people to share the responsibility in caring for this patient, I am afraid that the nervous strain would be too great for one alone.

There seems to be no opportunity for an adjustment in the patient's family that would make it possible to care for him adequately. Mrs. H. appears to be a woman of about the same age as her husband. Since his retirement and financial reverses she has tried to keep up the home and maintain essentially the standards of living to which they have always been accustomed. She has been unable to maintain a steady position as she wasn't physically able to run the home and work too. Also, business conditions have been such that she probably would have been unable to find full-time employment in her line of work and at her age. Certainly she would be very foolish to try to take care of her husband alone from the point of view of physical strength.

Then there are the children to be considered. One son is married and has a home and a family of his own to maintain and support. The other son is still single and living at home. At present he is learning a trade in the newspaper field in connection with the printing department. He has about three years more to serve on his apprenticeship. So at the present time he earns only enough for the bare necessities of life.

The only way that this patient might be cared for in his own home would be by hiring at least one attendant, with the help of a visiting nurse, the patient's wife, and son. But this arrangement is hardly feasible when one stops to review the family situation. I doubt very much whether they could find the necessary funds to pay someone to care for him for any length of time. Probably he would then have to be placed on relief and what little money that would bring in would hardly care for the patient adequately. It would seem better for the patient, his family, and the taxpayers to place him in a nursing home or state institution.

This plan would not necessarily mean that the patient would become a public charge. It would allow for the family to be free to go on with the newspaper activities (proofreading, typing, etc.) and continue such work as they are capable of doing. Steady employment would be possible for the patient's wife if she could find it. The son at home could continue his work unhampered. They would not need a large home. Perhaps a small apartment would suffice and the home which they now have could be rented at a figure which would offset the cost of their apartment and leave a little in addition. Perhaps they could arrange to have their home remodeled sufficiently so that they could live in one part and rent the rest of the house to good advantage. By doing this they would have some small income from real estate and provide themselves with a home at the same time.

Then if the married son could be persuaded to contribute a few dollars weekly and the wife from her income, it would be sufficient to pay the patient's board in a nursing home or at a public institution. I have known of similar cases where people have contributed money to public institutions to care for the incapacitated members of their families. It gives the family a feeling of independence and is far better than making public charges out of the patients or, as it might prove in this case, the whole family.

It is interesting to note here that the patient is still in the hospital. The doctors have recommended institutional care."

VIII. *Varicose Ulcers*

Student's Insights into Patient's Needs.

1. Awareness of patient's limited comprehension and need for specific detailed instructions.
2. Value of assistance of social worker in enabling patient to get to the dispensary for medical care.

3. Necessity of careful planning with patient for the home treatment of her ulcers.

4. Need for the use of simple terms in describing the care of her lesion, i.e., the use of pail, medication, length of immersion, period of day for treatment, applying dressing, and use of elastic bandage.

5. Need for demonstrating the method of elevating the foot.

6. Details of the plan for a period of complete rest and method of securing a housekeeper.

"Mrs. R. D. is an obese Polish woman who is being treated in the Surgical Out-Patient Clinic for the recurrence of a varicose ulcer. She is a huge, untidy individual who puffs and grunts as she moves about, wearing all the while an unintelligent, complacent grin on her flushed, perspiring face. She is not an unpleasant person to work with because she beams approval at every suggestion that is made. However, after repeated contact, the enthusiastic but inexperienced student begins to realize that perhaps her efforts are not penetrating very far behind that smile. She was born of Russian parents in Poland twenty-eight years ago. . . . She learned to speak English with a limited vocabulary and to read the newspapers and advertisements, but she says she cannot write. This is her excuse for not becoming a citizen. Outside her regular attendance at the Russian Catholic Church, she seldom leaves home. Some day she may visit her community center or evening naturalization classes but, for the present, she is pleased with life as it is, and does not care to move beyond her own doorway.

Her husband is also a Russian Pole of the same age. He works as a laborer with a wrecking company, earning from eighteen to twenty dollars a week. They have four children, two girls aged three and eight, and two boys aged six and ten. They live in five rooms in a three-family house in a poorer section of D. The children, as seen by the outsider, are not in any way unusual when compared with average poor American children. The entire family seems congenial and fond of one another. However, they live together in a dirty, unpleasant home with irregular habits. Meals are unplanned and often non-existent, there is no attempt made at house-keeping, either by the mother or other members of the family. . . .

The social worker urged Mrs. D. to come to the out-patient clinic. Mrs. D. pays her own ten-cent fare to the hospital and meets the worker outside the door. The social worker pays her admission fee and also purchases the prescribed medicines.

On October second, Mrs. D. returned to the Surgical Clinic. When the elastic bandage and a dirty cotton dressing were removed from her leg, an ulcer about the size and thickness of a fifty-cent piece and another about the size of a dime were revealed in an extensive reddened area just above the mid-point between the ankle and the knee. Her entire leg showed extensive varices and considerable pigmentation. The skin about the former area was considerably atrophied.

The patient was given a deep clorax foot soak. She was told to repeat this twice daily. In planning for these foot soaks at home, she assured us that she had a deep pail which she would scrub, turn boiling water into, and set aside for her soaking pail, and secondly she said that she would test the warmth of the water on her inner forearm. In considering her day's work, she felt she could best spare the half hour necessary for the twenty-minute soak at 10:30 in the morning and 3:30 in the afternoon.

Cod liver oil ointment and a dry sterile dressing were applied to the ulcers. The procedure was demonstrated to the patient. The cover from the ointment tube was removed and placed upside down on the clean newspaper which covered a chair to make a work bench. The ointment was applied, like tooth paste on to a toothbrush, at the side of the sponge that had not been touched. The sponge was held in place by a light bandage over the open lesions. The patient applied her own elastic bandage, winding from the ankle upward. As she was to return within a week, it seemed inadvisable to complicate her instructions with directions for sterile supplies, so she was asked to buy sterile pads at the drug store and to keep her dressings and salve in an oatmeal box. She had a change of bandage so that the elastic one could be washed. Her mother was to come to her home for several days so that the patient might have bed rest. After that she was to rest as much as possible with her foot elevated.

On the patient's return on the eighth day, the ulcers were clean and healing quite well. The bandages were clean, satisfactorily applied and she said she had been soaking her foot. Her mother had not arrived, however, and Mrs. D. had made no change in her plans for resting. Dr. — approved the social worker's suggestion that a housekeeper be placed in the home so that Mrs. D. might go to bed for a week. It was explained how home-made dressings could be baked, but since on the following visit she was not using them, it was concluded that she was not interested. Consequently,

I concentrated on encouraging her to soak her legs and to rest. The housekeeper plan had enabled Mrs. D. to stay in bed until the week-end, when she sent the worker away. The leg on this visit seemed unchanged. . . ."

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14

Daily Patient Assignment

DEFINITION OF THE ASSIGNMENT

THE ASSIGNMENT is the laying out of a task and procedure for physical and mental work. This is the more usual concept of the word "assignment" in general education. Further insight into its more general use is helpful in comprehending its importance in ward teaching.

According to Bossing,* "the assignment applies to that part of the instructional activity devoted to the clear recognition and acceptance by the pupil of the next unit of learning to take place and of the processes by which this learning may be achieved most effectively."

Bossing says that this definition recognizes four factors: *

- "1. Laying out a task to be done.
2. Fitting to the task an appropriate procedure for accomplishment.
3. Teacher direction but pupil acceptance of task and procedure.
4. Assumption that the most effective learning is the product of pupil activity self-imposed."

FUNCTIONS OF THE ASSIGNMENT

The assignment offers the head nurse an opportunity to direct the student's learning and provides a stimulus for further learning. It should tax the full capacity of the learnings thus far, as a challenge to greater ability. The selective assignment provides situations of increasing difficulty and responsibility. Frequently the head nurse does not seem to appreciate the importance of the assign-

* Bossing, N. L.: *Progressive Methods of Teaching in Secondary Schools*, Boston, Houghton Mifflin, 1935, p. 223.

ment and as a result the work of the student suffers. One of the major causes of poor student work is the hurried and careless assignment.

The five functions of the assignment according to Bossing are to: *

“1. Define clearly and concisely the task to be done.

2. Anticipate special difficulties in the advance work, and suggest ways to overcome them.

3. Relate new tasks to work previously done.

4. Motivate properly the work to be done.

5. Make adequate provisions for individual differences.”

A brief discussion of each function may prove helpful.

1. The student must see the reason and values in the assignment. If it is clearly defined, it will tend to focus attention on the goal and reduce the wasting of student time.

2. New learning situations present difficulties to the student but at the same time offer a responsibility and an opportunity to the head nurse. If, for example, the plan of care involves the application of a new principle, this should be brought to the student's attention.

3. A background of experience offers a basis for an understanding of the present situation. The head nurse may do much to help the student to see similarities in patterns of care and patients' needs.

4. The head nurse has a real responsibility in the grading of assignments to the capacities of the students. Interest is sustained more satisfactorily if the task is within the ability of the student. “To require a student to do something without regard to his interest or enthusiasm in the enterprise is generally frowned upon. . . . First, modern psychology has discovered that the student does not learn as readily when he has no interest in the thing to be learned. . . . Secondly, the effective development of habits and attitudes is directly related to the problem of motivation in learning. If, while learning is taking place in a particular situation, it is accompanied by a lively interest and enthusiasm, a favorable attitude toward that type of activity may be awakened.” †

5. If the head nurse recognizes the fact that individual differences do occur in students, she will take this into consideration when planning assignments. “All studies in mental measurements agree that among young people there exist vast differences in intelligence,

* Ibid., pp. 226-231.

† Ibid., pp. 229-230.

aptitudes, and temperament. Even the interests of students are found to be widely divergent.” *

TECHNIC OF MAKING THE ASSIGNMENT

Fundamentally, the selection of patients for the daily student assignment is based on a knowledge of the clinical resources of the particular ward or division, the previous clinical experience of the student, and the length of her period in the school.

Knowledge of the clinical resources of the ward may be obtained by a ward analysis of cases during a one-year period. The head nurse may begin such an analysis at any period of the year and continue it as new patients are admitted and others discharged. Such a study usually includes the name of the disease condition, the length of hospital stay, and the month or seasonal incidence of illness. It affords insight into the possible experience available for assignment and the potential number of days which the average student may be assigned to give care in a disease condition, without decreasing the experience of other students. For the major disease conditions, the student should give care to the same patient for at least one week. The available experience should be studied in relation to the master list of disease conditions which is given on pages 567-587 of *A Curriculum Guide for Schools of Nursing*.† This comparison will help the head nurse to know which conditions occurring on her floor are most significant and hence should be essential experience for all students.

The previous clinical case experience of the student may be ascertained through the use of a case-experience record on which is recorded the number of days' care given to patients with basic disease conditions. A sample sheet such as may be used in pediatric nursing is shown on page 285.

Case experience is recorded by daily marking of nursing care in the square opposite the diagnosis with a 1, 2, 3, or 4, indicating whether this is the first, second, third, or fourth patient with this diagnosis to whom the student has given care. One space is used each day for each patient to whom care is given.

EXAMPLE: If the student cared for two arthritic patients today, she would record this as |1|2|. If tomorrow she cared for the second

* Bossing, N. L.: *Progressive Methods of Teaching in Secondary Schools*, Boston, Houghton Mifflin, 1935, p. 231.

† National League of Nursing Education: *A Curriculum Guide for Schools of Nursing*, New York, 1937.

patient only, she would record a 2. Only one number is placed in each space. No differentiation is made as to sex.

In a hospital with non-segregated clinical services, a record of case experience is particularly helpful in selecting patients for assignment. If ink of a different color is used to record experience in the private division, the conditions may be noted for which less bedside teaching has been given and, as well, additional assignments planned.

Complete case experience for all patients assigned is not indicated unless a minimum of experience is available, but a record of experience in caring for patients with major disease conditions is highly desirable and essential to good methods of clinical assignment. How else can the head nurse provide for a well-rounded experience?

The length of time the student has been in the school is essential information for the head nurse. With a knowledge of the available clinical experience on a ward or division, and of the previous experience of the student in this service, the head nurse may plan what case learning is most essential for a third-year student who has, for example, from seven to ten days remaining on her ward.

Hence the head nurse makes her daily assignment on the basis of available experience, significance of disease conditions, experience of the student in the school, and ward need.

Suggestions in Making Selective Assignments. The following suggestions may aid the head nurse in effecting satisfactory assignments:

1. If the student is uncertain as to her ability to care for a patient with a certain condition, provide her with the essential background so that she can progress satisfactorily. Either a reading assignment or provision for assistance in the giving of care may be essential. Do not assume this knowledge and ability unless you *know* the student has it.

2. Early in the assignment, challenge the student to enlist her interest and maximum effort in the work. Review the student's plan of work. If the student is advanced, suggest some further advanced plan of care.

3. Estimate the student's grasp of the work ahead. You may do this by a major question, by asking the student to summarize the main points to keep in mind, or by a written quiz or assignment.

4. Suggest a division of time in caring for several patients, and time limits.

5. Be specific about reference reading.

6. Plan to have the student give care to the same patients for at

least a week. If the assignment changes daily, it is not selective, and the student has little opportunity to know and plan for the patient's special needs. If the student is writing a nursing-care study, plan to have her care for the patient for several weeks.

DAILY ASSIGNMENT SHEET

These are many forms in use for the daily assignment of patients to nurses. Some forms represent one day's plan only while others represent the daily plan for the period of a week.

A daily plan seems preferable, as it shows exactly what nurse is responsible for giving care to the individual patient for the 12-hour day period. A sample nurses' assignment sheet is shown on page 237. On this sheet the patients' names are listed in the left-hand column, the nurses who are responsible for the patients, on the right. The graphic line beginning at 7:00 A.M. represents the period of time the nurse is on the ward from 7:00 A.M. to 7:00 P.M. The interrupted red line represents the period when she is off duty, with the initials in red of the nurse who is giving relief care. The initials of the relief nurses usually are written in with red pencil. Hence on the sample assignment sheet, Miss F. Smith is responsible for Mrs. Margolis, Mrs. Steeves, and Miss Bates from 7:00 A.M. to 3:30 P.M. When she goes off duty at 3:30 P.M., B. G., or Miss B. Green assumes responsibility for these three patients,—as well as for her own three patients,—until 7:00 P.M. The letter L. represents lunch, and D., dinner. Relief is assigned across the meal hour for a very ill patient only.

A criticism might be that at one period during the early afternoon only two nurses were on duty to give care to patients and hence it would follow that each would take responsibility for one-half of the patients. However, the assignment sheet shows specifically what nurse does give care, how heavy the load is, and provides more nearly for the same relief nurse on each day. Assignment of students for relief periods is an important responsibility of the head nurse. So often upon this the success of the planning may hinge. The head nurse should constantly keep in mind that the patient should be given to the same relief nurse as frequently as possible and find it necessary to adjust to as few nurses as possible. In the words of one asthmatic patient, "Do I have to adjust to all six nurses every day?"

In changing from the functional to the case method of assign-

MASSACHUSETTS GENERAL HOSPITAL
TRAINING SCHOOL FOR NURSES

Ward *B₂*Date *2-10-41*

NURSES ASSIGNMENT SHEET

Patient	7	8	9	10	11	12	1	2	3	4	5	6	7	L.	D.	Nurse—Special Assignment
1. Mrs. Margolis																<i>Miss D. Smith</i> Senior Duties Charts Dressing Cart Count of Instruments Treatment Room
2. Mrs. Stevens																
3. Miss Bates																
4.																
5.																
1. Miss Avery																<i>Miss B. Green</i> Linen Closet Prepare patients for trays Carry trays
2. Mrs. Kelly																
3. Miss Anderson																
4.																
5.																
1. Mrs. Bradley																<i>Miss R. Jones</i> Utility Room
2. Mrs. Ames																
3.																
4.																
5.																
1. Mrs. Clarke																<i>Miss A. Brown</i> Tub Room Common Closet Carry trays
2. Mrs. Dustin																
3. Miss Allen																
4.																
5.																
1. Miss Mancuso																<i>Miss J. Smith</i> Kitchen
2. Mrs. Tyler																
3. Miss Shandfsky																
4.																
5.																
1. Mrs. Adams																<i>Miss L. Frank</i> Medicine Closet
2. Miss Beck																
3.																
4.																
5.																

FIG. 18. Form for Assignment Sheet.

ment, it may seem necessary to use a weekly sheet as an intermediate step. However, in both instances, the names of the patients should be listed rather than room numbers. This helps the nurse to learn the patients' names more quickly and to individualize the patients.

INCREASING THE LEARNING VALUE OF THE ASSIGNMENT

A plan to provide skilled assistance to the first- and second-year students in the giving of bedside care assures and increases the learning value of the experience. It is a good method of making the assignment effective.

Before planned ward instruction was an accepted requirement in schools of nursing, good practice called for a younger or beginning student to assist an older, more skilled nurse in the giving of bedside care to an acutely-ill patient. This was both learning through doing and through observation.

These same rudiments may be applied today in a more highly specialized form—that is, with planning of the observation and assignment so that a more perfect concept of good nursing care in the actual situation may be obtained. The degree of responsibility for the patient must gradually shift from the more experienced to the less experienced nurse. The rapidity of shift is determined by the insight, understanding, and technical skill of the nurse.

The younger nurse, a student, is assigned to two or three patients, one of whom presents one or more nursing problems in relation to the giving of morning care or late afternoon care. This might be referred to as one kind of selective assignment. The student plans her procedure for care and treatment in an apparently logical order. She may even write out her plan for dovetailing the treatments of her several patients to complete her morning's program of work within the allotted time. With guidance, she assumes the responsibility for the several patients.

The head nurse has arranged for an older, more experienced nurse, either a third-year student or preferably a staff nurse, to work with the student. Together they discuss the plan which the student has set up, giving careful attention to time allowances. The student assembles her equipment and notifies her co-worker when she is ready to begin care. The student carries the load of care, while the

older nurse supports the patient, conserves the patient's strength, observes the student's workmanship, and by action, glance, or comment directs and hence teaches the student. The student thus works with greater confidence, and hence with more ease, because she feels that the patient is not suffering through her lack of previous experience. This is not apprenticeship learning, for the young nurse *is* assuming increasing responsibility, under direction, for the assigned patients.

More direction than this may be necessary, depending on the condition of the patient. An acutely-ill patient with pneumonia who may be receiving oxygen by catheter, mask, or tent, is best cared for by the more experienced nurse, the younger student assisting. This is *not* experience for a young student unless considerable supervision is given. The student may make the plan for morning care, but in the actual giving of the care the supervisor or head nurse assumes the major responsibility, while the student assists by supporting the patient, furnishing fresh equipment, and observing the patient's reactions. One cannot *tell* a young student exactly how to give care to a patient with pneumonia for the factors which cause fatigue in one patient may not hold true in another. One *can show* a second nurse how to modify the pattern of care for an individual patient with pneumonia, by actually carrying the responsibility for bedside nursing care for a period of approximately 30 minutes. From experience, the supervisor will learn what personal joy this brings—the joy of being a bedside nurse—, what comfort this brings to the pneumonia patient, and what satisfactory results this produces in terms of good nursing care later in this same condition by the student nurse. How to turn the patient, when to give a sip of fluid, when to limit the bath or allow for a rest period, how to rub the back in relation to the location of pleuritic pain and pain from consolidation—these aspects cannot be predicted but they can be shown as morning care progresses and the patient's condition requires their consideration. This may be considered a form of apprenticeship learning.

The supervisor and head nurse must determine whether the student has progressed sufficiently to take the major responsibility for the care of the acutely-ill patient. Such a decision never rests on the period of time in the school. It must depend on an analysis of the ability and experience of the individual student. Every student at times needs help in giving nursing care. By so doing, "irregulari-

ties in abilities and individuality in tastes and application, are more easily met." *

Again it is well for the ward supervisor and head nurse to keep in mind the three psychological principles of "observation." †

- "1. The superior vividness of reality as over against symbols.
2. Impression through several senses is most effective.
3. 'Learning by doing.' "

The significance of observation must be stressed before the student enters the patient's room and the quality of observation evaluated after the care is completed. Looking is not enough. A casual glance reveals little. Concentrated observation with mental consideration or contemplation is essential. Does the nurse *observe* the signs and symptoms and *reflect upon* their nursing implication in relation to this patient? "Look hard, dear student, and interpret what you see." Such an admonition, given at intervals, might increase the thoughtfulness of our care.

The older nurse in assisting the student at the bedside may aid the student in making the observations which both the doctor is relying upon in part for his plan of treatment and which she herself needs for an adequate course of nursing care.

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* Stormzand, M. J.: *Progressive Methods of Teaching*, Boston, Houghton Mifflin, 1921, p. 359.

† *Ibid.*, pp. 203-204.

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15

Teaching Aids

Kinds of Teaching Aids. The following kinds of teaching aids may be useful in ward instruction:

The patient

Body fluids and slides of tissues or organisms

Charts, graphs, diagrams, roentgenograms

The ward library

Pamphlets for teaching of patients

Bibliography

Teaching cards

THE PATIENT

Whenever the patient is available and not too ill to be shown or seen for teaching purposes, he makes the best kind of teaching material. Case illustration is of paramount importance in ward instruction. This is understandable when one perceives that the major purpose of ward instruction is to improve the nursing care of the patient. Showing the patient stimulates immediate interest, provokes observation and mental activity. Little discussion need take place in the patient's presence.

Only the patient who wishes to come to the ward classroom is brought to the learning group. The supervisor or head nurse explains to him in advance what the purpose of the discussion is—that is, usually, to have all of the nurses in the ward understand how his care should be administered and to understand his problems a little better so that he may have the best care possible. Often it is sufficient to go to the bedside in two or three small groups at the end of the teaching period to observe specific symptoms or aspects of care. To show apprehensive, edematous Mr. Peters, a

nephritic, immediately following a discussion of the symptoms of nephritis makes the clinical picture linger. To see the correct application of a paste and cotton face mask to the sweet face of a child with eczema is far better teaching than to see the diagram of the mask and to hear how to apply the ointment. And again, to see and understand the purpose of the Miller-Abbott double-barreled duodenal tube and then go to the bedside of the patient and observe the head nurse carefully withdraw 30 cc. of duodenal fluid from the correct outlet is far more significant than to see the tube outside of the patient only.

BODY FLUIDS, SLIDES OF TISSUES AND ORGANISMS

The several body fluids as they appear in various disease conditions present excellent illustrative material. These include urine, blood, vomitus, gastric and duodenal contents, stools, spinal fluid, synovial fluid, peritoneal fluid, wound drainage, and postoperative cavity drainage. The fluids may be present at the bedside, saved on the ward for teaching purposes, or obtained from the laboratory.

To show a specimen of smoky urine from a patient receiving a sulfonamide and to explain this sign to be a precursor of hematuria is meaningful teaching. To see the blood hemoglobin test which stands at 45 per cent in Mrs. White who is suffering from pernicious anemia, to glance at the blood-tinged vomitus of Mr. Miller who has a bleeding gastric ulcer, to demonstrate the gastric contents following a "fasting meal," to present the variations in diarrhetic stools, to show the characteristics of the synovial fluid withdrawn from the knee of Mr. Green who has gout, to display the kind as well as to measure the amount of postoperative cavity drainage for the patient on continuous suction and to ensure understanding of the significance of these fluids in the instance of the particular patient, is profitable ward teaching. Emphasis is not on the fluid as a specimen but rather upon the quality of the nurse's observation of the specimen.

Slides of tissues and of disease organisms also add interest and help to integrate the biologic sciences with the individual patient at hand. To study the stained slide of the organism when Mr. Jones with a positive gonococcic arthritis is on the ward, is both interesting and advantageous. The science instructor may be able to furnish each head nurse and supervisor with a list of the classroom slides of tissues and organisms available for ward loan.

CHARTS, GRAPHS, MAPS, DIAGRAMS, X-RAYS

The possibilities for the use of charts and graphs are innumerable. Various kinds of charts include the printed anatomic chart, the dia-

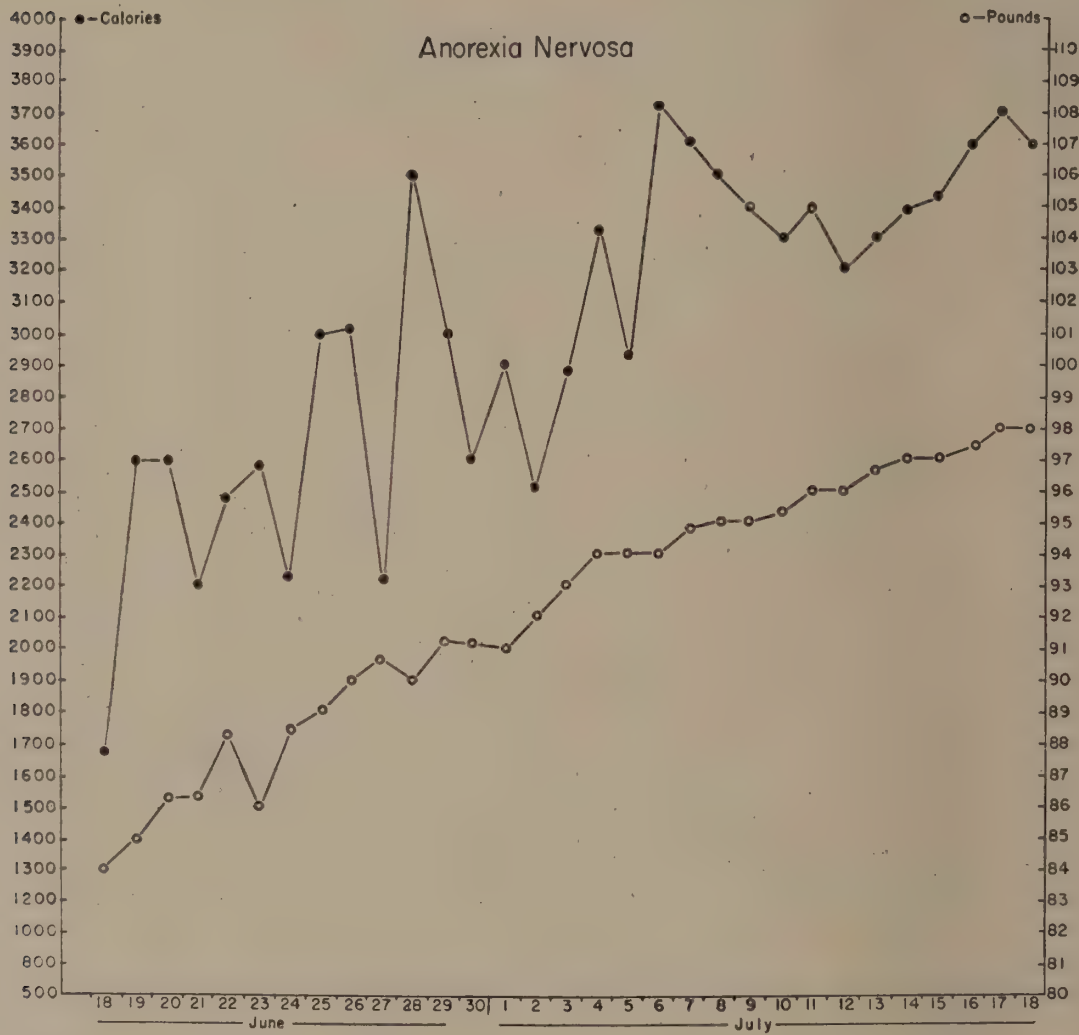


FIG. 19. The weight gain in relation to the caloric intake in a woman who was markedly underweight. This simple day-to-day chart encouraged the patient, the dietitian, and the nurse.

grammatic chart of organs, cavities, surfaces, or tissues, the graphic chart of the reaction of one or more patients to drugs or treatments, the common and cardinal symptoms, and the patient's clinical chart.

Several of the Frohse and Michel anatomy charts are excellent for ward teaching. From several companies it is possible to obtain

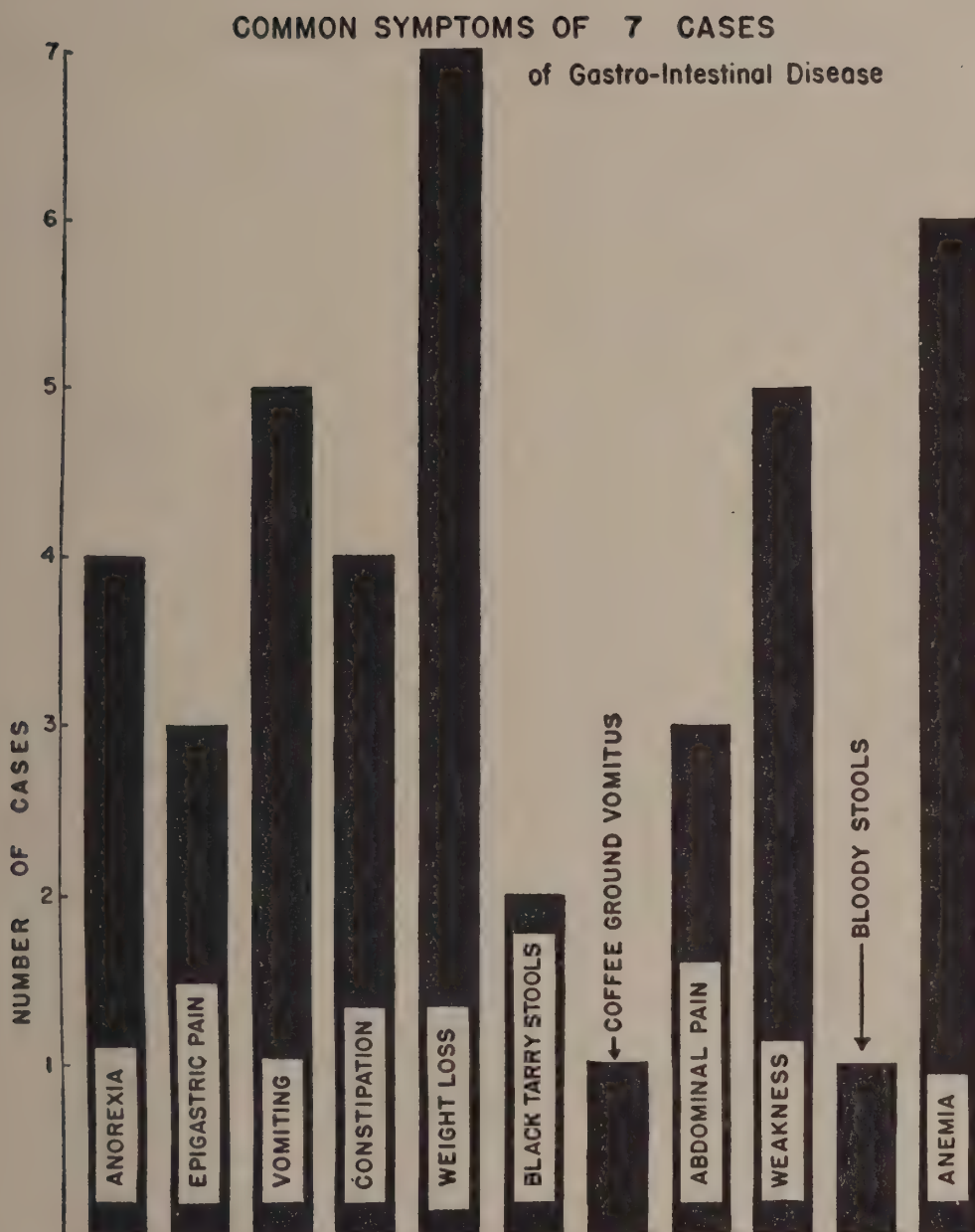


FIG. 20. A graphic method of presenting symptoms of significance to the nurse.

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a particularly desirable selection. These anatomic charts may be borrowed from the teaching departments for particular mornings. If a ward classroom is available, it is well for the ward supervisor to build up her own collection of printed charts for ward use.

Maps of the township or city and state are helpful in locating the patient's home and in appreciating the potential travel which will be required for follow-up visits to the out-patient clinic. Outline

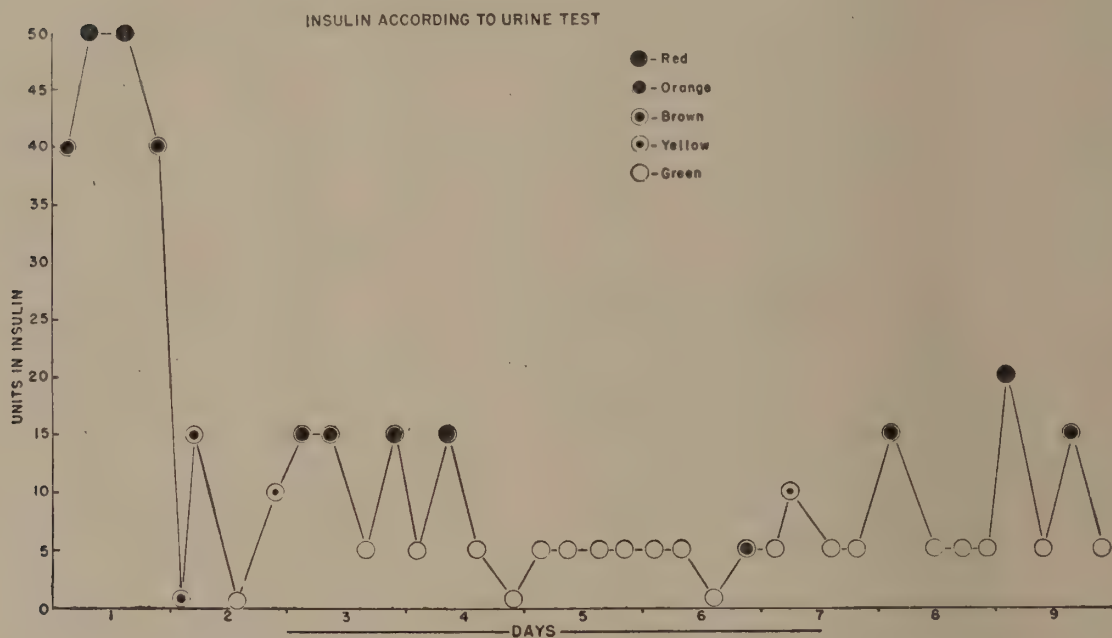


FIG. 21. The relationship of insulin dosage and urine test in a patient with diabetes. Variation in the doctor's order for insulin dosage may be noted through the sixth hospital day.

maps of the state, which in some instances may be obtained free upon request from the State Department of Health, may be used for spot maps of cancer clinics, tuberculosis sanatoria, and clinics for crippled children.

From discarded text and reference books, illustrations may be cut and mounted. The mounting should be of a standard size (not larger than $8\frac{1}{2} \times 11$), to permit filing. X-rays may be helpful teaching material, though a photograph of an x-ray is more useful. This permits the use of the x-ray picture without the necessity of an illuminator. Also it may be filed as permanent teaching material while the x-ray film often must be returned to the x-ray department.

Several graphs, clinical charts, and diagrams are shown as examples of good illustrative material. The originals were made by students, head nurses, and supervisors. The charts have been kept as simple as possible. See Figures 19, 20, 21, 22, 23, and 24.

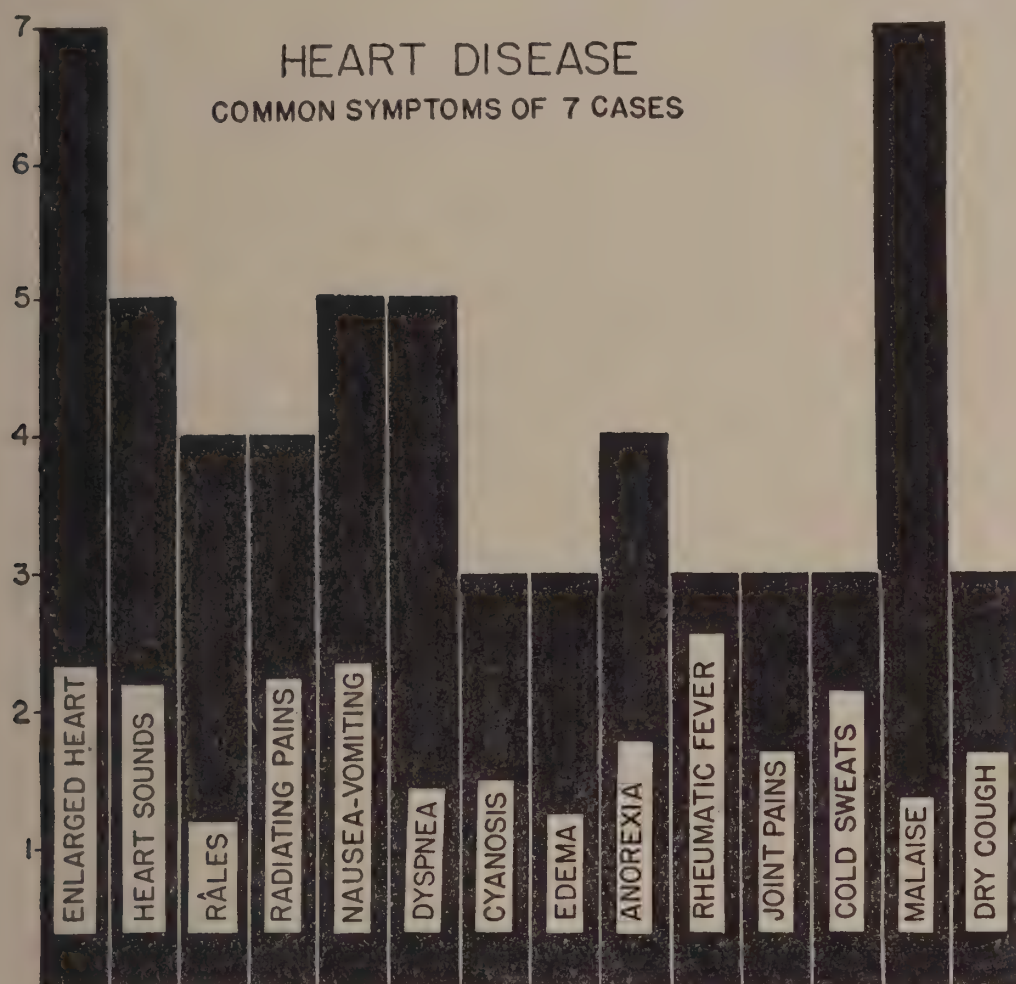


FIG. 22. Signs and symptoms may be summarized for the important disease conditions by the column graph. This one was made by a first-year student.

THE WARD LIBRARY

The ward library is a tremendously significant teaching aid. Good ward teaching cannot progress without a growing ward library. Up-to-date clinical information needs to be near the patient and the patient's record. It is difficult to understand how a medical head nurse could progress without ready access to Cecil's *Textbook of Medicine*, a surgical head nurse without Homan's *Textbook of*

LOBAR PNEUMONIA

TYPE-1.

TYPE-2.

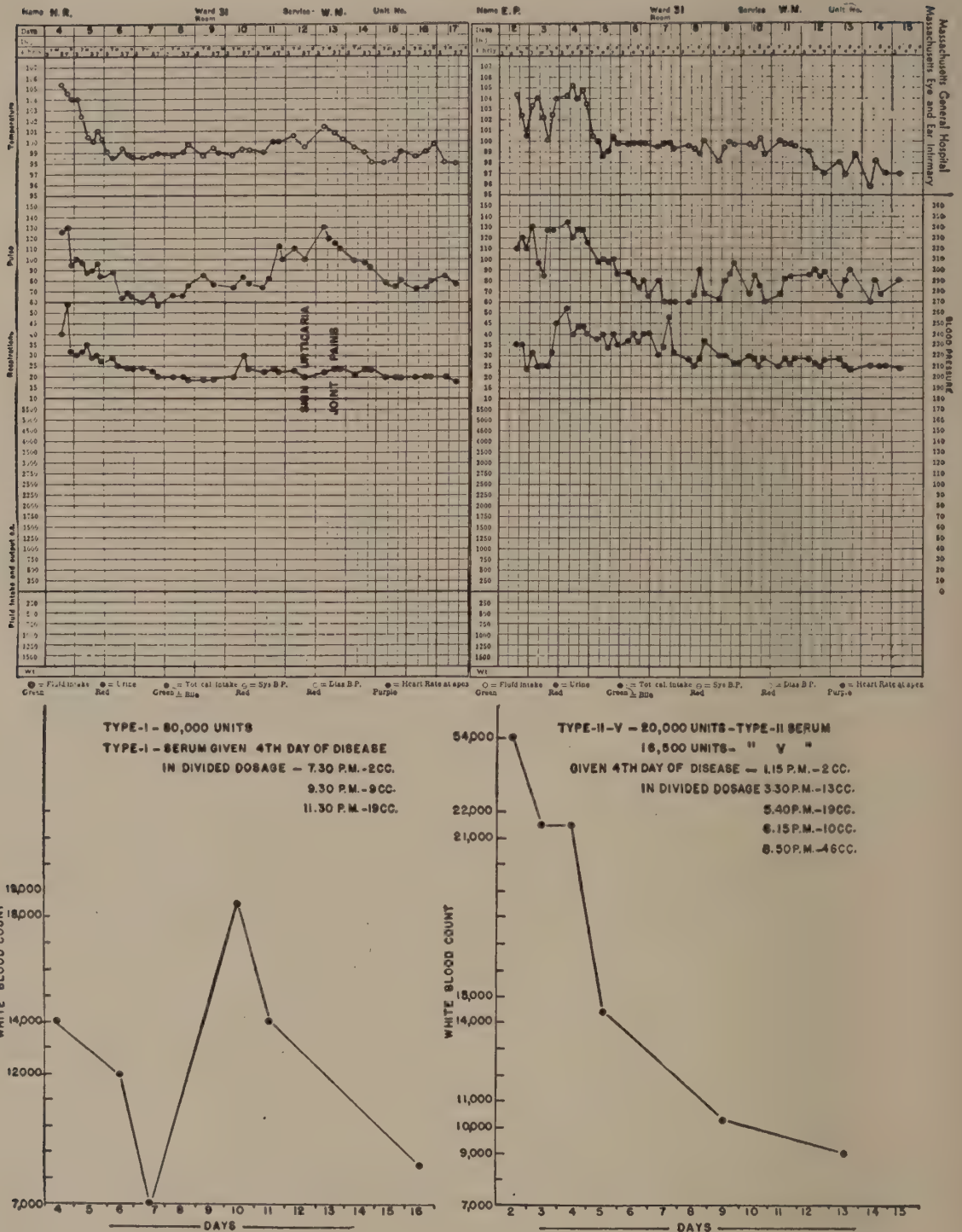


FIG. 23. The relationship of serum injection in pneumonia to the decrease in temperature, pulse, respiration, and white-blood-cell count.

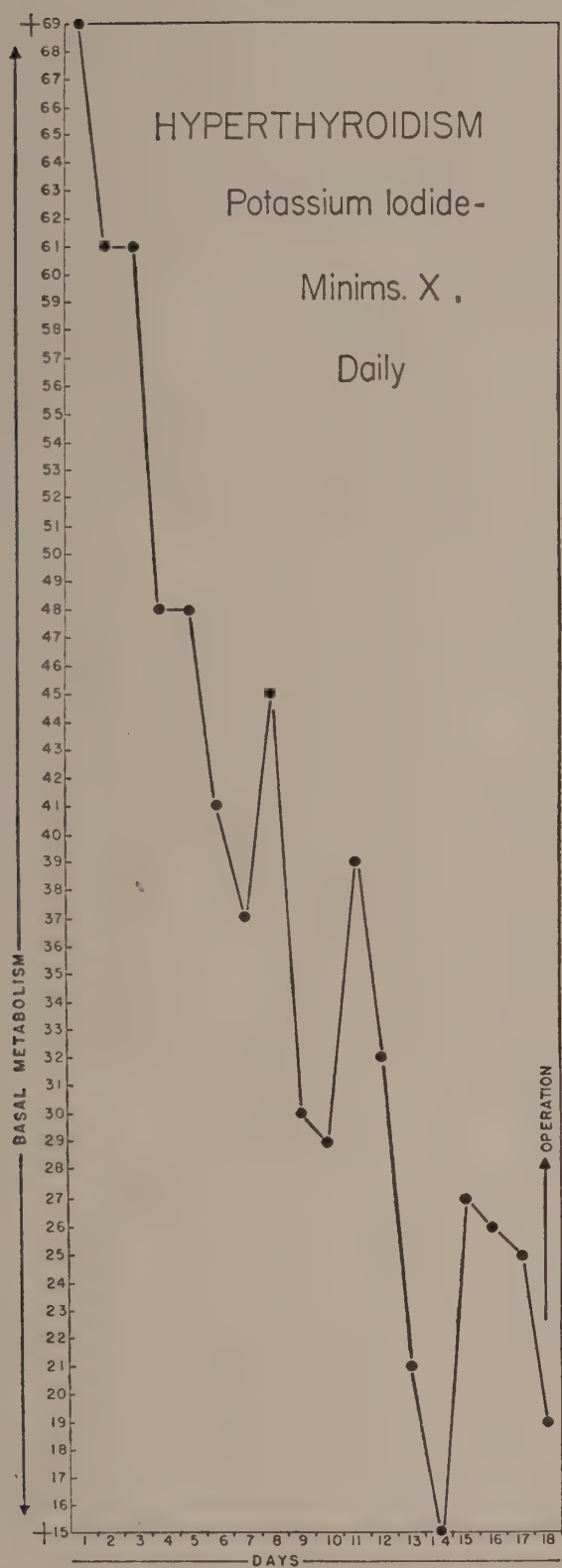


FIG. 24. The decrease in the basal metabolism rate with the daily administration of potassium iodide, minims x. This chart is used to point out the value of this medicine in the reduction of the basal metabolism.

Surgery, or any head nurse without the *American Journal of Nursing*.

The ward library should be, as the term implies, on or adjacent to the ward. It should include the standard textbooks in current editions, in use by the students in the school of nursing, a medical dictionary, a standard English dictionary, the head nurse's copy of the *American Journal of Nursing*—if not otherwise provided for—, the selected reference books for the particular clinical specialty, the nursing procedure book for the general and special clinical service, pamphlets, and reprints of articles in current medical periodicals.

The American Journal of Nursing is one of our outstandingly helpful teaching aids. To all nurses it brings current, authentic information regarding disease conditions and their nursing care, new medicines, new treatments, newer nursing procedures, and improvements in common nursing technics and improvised equipment. The *Journal* in itself is an important prerequisite of a good ward library. There are several ways in which it may be used. The head nurse may make available the current issue and the particular issues used as reference for the week's ward-teaching program. She may wish to keep her magazines in the supervisor's office or other storage space near the ward, and obtain them as references demand. She may borrow the supervisor's back issues—since many head nurses are young and have subscriptions of but one or two years—making them available for reference.

The annual index, which is available to each subscriber, is useful to the head nurse in looking up references on disease conditions and nursing care. In the index, references are given under the major headings, "Medical Nursing" and "Surgical Nursing" as well as under the specific disease condition. This makes the index a handy source of reference for the busy head nurse.

She may wish to obtain reprints of certain articles or to clip out articles which can be more easily filed than *Journals*. Several articles which head nurses have clipped for ward reference include the following:

1. For explanation of use of continuous gastro-intestinal suction:
Paine, John Randolph: Nasal Catheter Suction-Siphonage, *Amer. Jour. Nursing*, 39:121-126, 1939 (February).
2. For instructions regarding a plan for teaching the diabetic patient and administration of protamine-zinc insulin:
Langhart, Iris: Teaching the Diabetic Patient, *Amer. Jour. Nursing*, 36:319-324, 1936 (April).

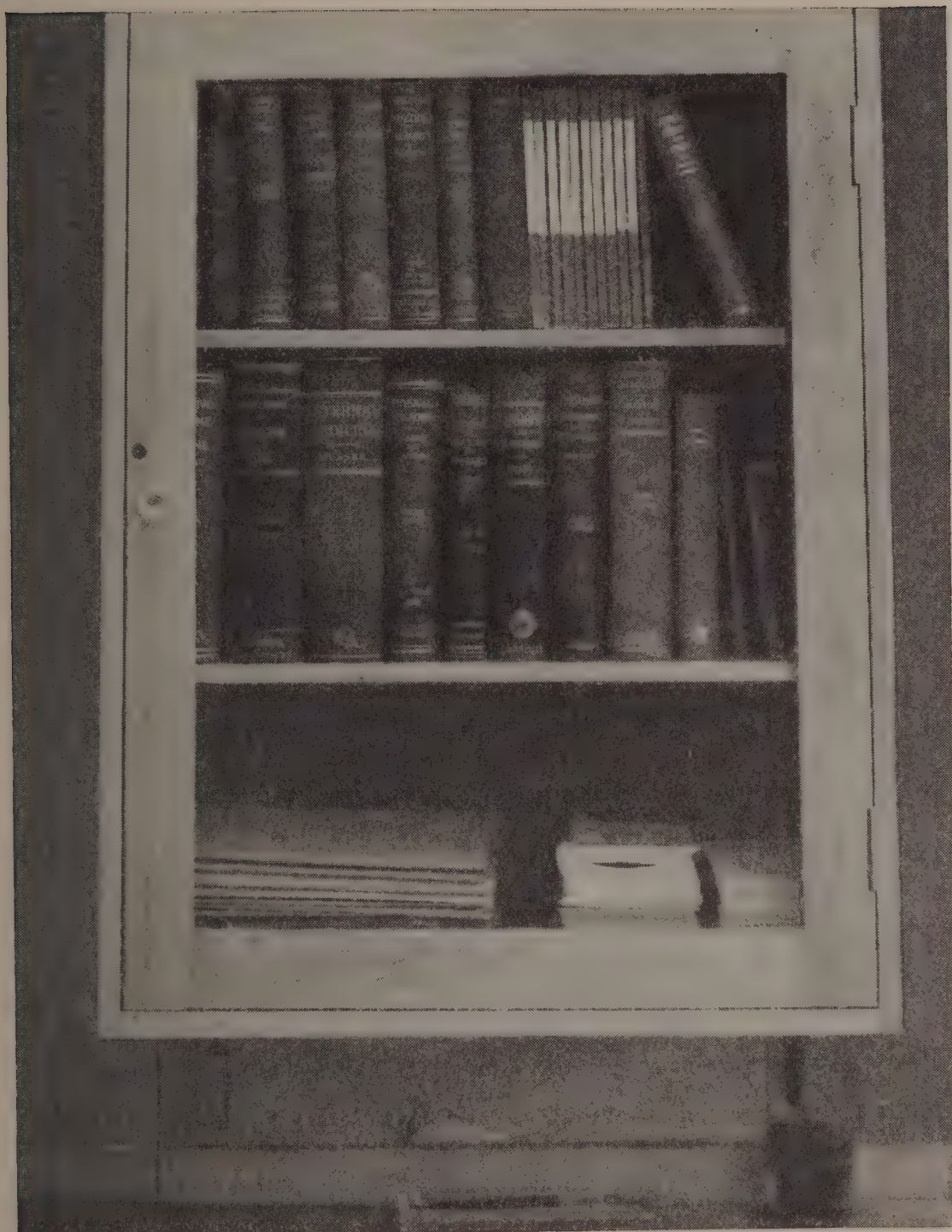


FIG. 25. The locked book case in the medical teaching room.
The key is kept in the ward.

Hildebrand, Alice G., and Kepler, Edwin J.: Protamine-zinc Insulin, *Amer. Jour. Nursing*, 40:527-534, 1940 (May).

3. For understanding and caring for the spastic child who recently has been admitted to the hospital:

Carlson, Earl R.: Understanding and Guiding the Spastic, *Amer. Jour. Nursing*, 39:356-366, 1939 (April).

Gorey, Margaret M.: Nursing Care of the Spastic Child, *Amer. Jour. Nursing*, 39:367-371, 1939 (April).

4. For specific data regarding the essentials of care following spinal fusion:

Pitman, Eleanor B.: Nursing Care in Spinal Fusion, *Amer. Jour. Nursing*, 39:728-732, 1939 (July).

The lists of "Free and Inexpensive Materials" occurring several times yearly also may be removed from the issues and kept available. There are several convenient ways of filing clinical information. A series of folders may be set up, either for each major disease condition for the clinical specialty, or for each unit or system. The folders marked with specific conditions and related procedures are particularly helpful and may be kept in a single drawer file of steel or cardboard. Articles also may be arranged in an indexed filing box or alphabetically in a notebook.

The supervisor will want to make available the back issues which she can obtain—older alumnae are helpful in this regard—in her office. Since nursing is becoming less specifically surgical or medical, most supervisors at present are less accustomed to clip their *Journals*. Diagrams occurring in various issues may be reproduced, with acknowledgments, as larger charts for teaching groups. Certainly, it is evident that the *Journal* is a fundamental teaching aid.

Ward Reference Books. These also are fundamental teaching aids. The standard clinical texts are more helpful for interpretation of the patient's case record and graphic chart while the nursing texts prove helpful for aspects and patterns of care. Both should be included in any ward library; and one without the other is quite inadequate.

The question arises as to whether borrowing from the nurses' reference library is a satisfactory procedure. Borrowing certain books is advantageous but the eagerness of the quest for knowledge doesn't propel the student to the library several hours after the question arose. On-the-spot references are needed. Was that a symptom of a drug reaction? The nurse needs to know at once. The more

skilled our observations, the greater the need for references. A more discriminating interpretation of observations develops with an increase in our fundamental knowledge.



FIG. 26. The special reference books are chained to the charting desk in the isolation ward. The standard textbooks used in the school of nursing are not chained.

Again, the student who is studying a patient's record with a view to writing a nursing-care study, where references are available on the ward, may sit down with the record and text, and interpret as she goes. The alternative is to make notes from the patient's record, with some error due to incomplete sentences and poor original writing, and after a variable time lapse interpret these notes in the school library. Quality studies usually are produced by students who interpret as they read the record.

The list of reference books given at the end of this chapter has been found particularly useful for ward libraries. Certainly many other books are available. Perhaps this list of suggested books may stimulate the growth of ward libraries in schools of nursing. The "Basic Book List" published by the National League of Nursing Education lists many of these and other reference books with price.

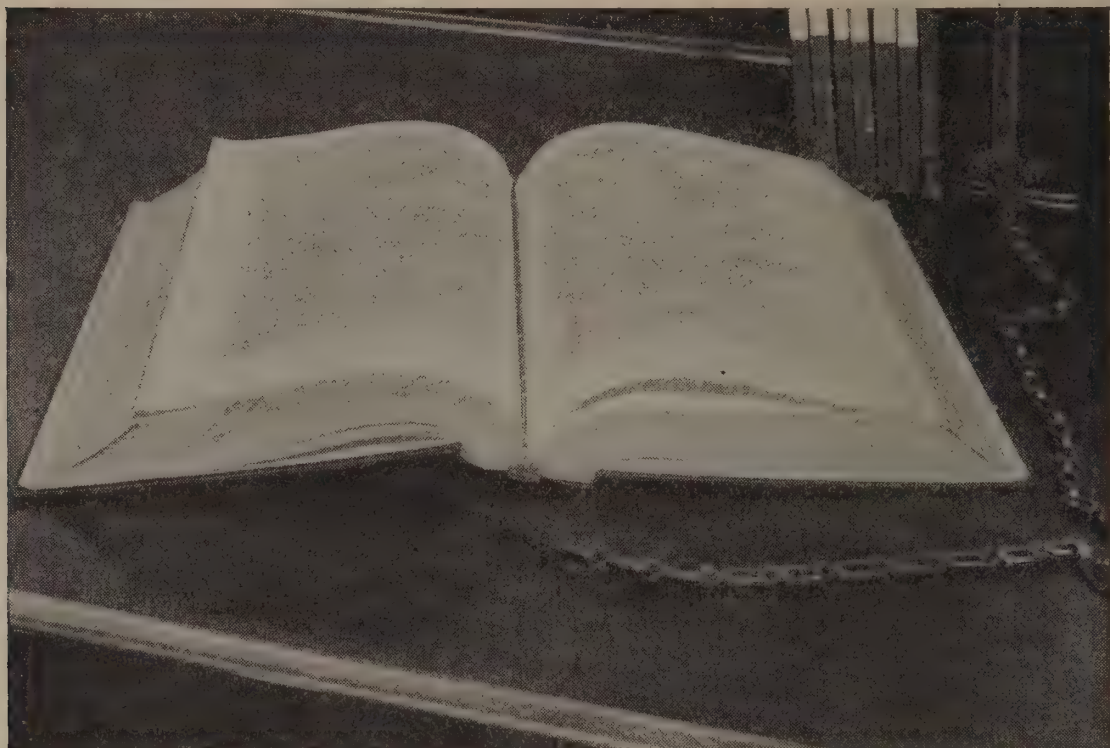


FIG. 27. The metal wire placed lengthwise through the center of the book is welded at top and bottom to the flat half-inch wide back strip.

Nursing Procedure Books. On each ward of the hospital there needs to be an up-to-date copy of the basic nursing procedures. The student would have learned these procedures in the course, *Introduction to Nursing Arts*. This book, perhaps of mimeographed sheets in loose-leaf form, should be readily available for reference. Photographs or diagrams showing details of procedures are good to include as well as procedure sheets, for the eye-minded. Keeping the book up-to-date is usually the responsibility of the instructor in nursing arts, while making it accessible is the responsibility of the ward supervisor or head nurse.

A book containing a description of special nursing procedures and methods of care, in a special clinical service, may be set up to advantage. For example, on the pediatric, skin, or orthopedic and

neurologic services, special nursing procedures are used, and as a teaching and reference aid a detailed description would be extremely useful.

Pamphlets and Reprints. Many pamphlets of variable quality and usefulness are available to nurses. A pamphlet should be documented or bear the name of a professional worker to be authoritative. Most reliable agencies which publish health education material document their publications. Commercial pamphlet material is used advantageously by many private agencies. However, its use is not permitted by most state health departments, as they cannot give preference to the advertising material of any commercial organization. Hence a nurse working under a private health organization would have use of a wider range of pamphlet material than would a nurse associated with the city or state health department.

Reprints from articles published in professional periodicals are available from many authors. They may be obtained usually by writing to the author. Several health organizations regularly publish a leaflet of available reprints and pamphlets. These may be obtained by addressing the organization. A suggested list of organizations from which this type of material may be secured is given on page 262.*

Another listing of pamphlets and reprints occurs frequently in the *American Journal of Nursing*. These are useful in building reference material of value in teaching nurses and patients. As this information and the lists are being revised constantly, this type of material should be weeded out fairly often and only the more recent materials retained. Its real usefulness depends on its being up-to-date. It is listed as "Free and Inexpensive Materials" and is prepared by the *American Journal of Nursing*. References to several of these lists are as follows:

Cancer and Malignancies; 38:313-314, 1938.

Communicable Diseases; 38:85-86, 1938.

Communicable Diseases; 40:109, 1940.

Dental Health and Hygiene; 37:1272, 1937.

Diabetes; 40:315-316, 1940.

Drugs and Treatments; 38:467-469, 1938.

Eye Health; 38:936-938, 1938.

* An excellent annotated list of health education materials is given in a "Bibliography in Health Education for Schools and Colleges" by Mary Ella Chayer, published by G. P. Putnam's Sons in 1937.

- Food and Nutrition; 38:736-738, 1938.
Food and Nutrition; 39:675-676, 1939.
Food and Nutrition; 40:1396-1398, 1940.
Health and Medical Economics; 37:1047-1048, 1937.
Hearing and Deafness; 39:1368-1369, 1939.
Hospital Housekeeping and Management; 37:1157-1158, 1937.
How to Use Reference Materials; 40:1267-1268, 1940.
Maternal, Infant, and Child Welfare; 37:421-423, 1937.
Maternal, Infant, and Child Welfare; 38:405, 1938.
Maternal, Infant, and Child Welfare; 39:428-430, 1939.
Maternal, Infant, and Child Welfare; 40:439-440, 1940.
Mental Hygiene; 38:832-833, 1938.
Orthopedics and Surgery; 40:1036-1038, 1940.
Poliomyelitis; 40:1364, 1940.
Recreation (applicable to diversions); 38:597-599, 1938.
Safety, Accident Prevention, and First Aid; 37:543-544, 1937.
Sex Education; 39:198-199, 1939.
Sex Education; 40:180, 1940.
Sex Education; 41:220, 1941.
Supervision and Teaching; 40:812-813, 1940.
The Care of the Aged; 39:301-302, 1939.
The Heart and Cardiac Conditions; 38:1157-1158, 1938.
Tuberculosis; 37:1399-1400, 1937.
Venereal Disease; 38:200-202, 1938.
Venereal Disease; 39:198, 1939.
Venereal Disease; 40:180, 1940.
Venereal Disease; 41:219-220, 1941.

Pamphlets for Teaching Patients. State health departments, private agencies, and hospitals publish many leaflets and booklets at considerable expense, relating to the promotion of health. These are available, usually without charge, and contain helpful information for the nurse to use in instructing the patient. The information is couched in simple terms. A pamphlet may answer one or more questions and contain other helpful suggestions for the patient.

These pamphlets have been made freely available in the out-patient clinics of several hospitals and in the wards. They should be approved by the medical service of the particular clinic in which they are used. They vary as to clinic, service, and as to season. They may be placed in a heavy cloth bag of a dark color which can hang on the back of a door or beneath a bulletin board where

health news is posted. The patient may help himself, so to speak, or a nurse may give a pamphlet in answer to a question, with some few words of explanation, underlining, or writing in of any special additional directions.

How Several Nurses Have Used Pamphlets in Teaching Patients. The following remarks explain several ways in which students have found pamphlets useful in instructing patients:

"I used a dietary booklet from the State Health Department to instruct a patient who has subacute bacterial endocarditis. Her family income was low and the booklet suggested well-balanced menus for persons in that income group. It also gave recipes which required the use of cheaper but adequate foods."

"In the Medical Clinic, a booklet on choosing foods for their values was gratefully accepted by a man who had been told to watch his weight, yet had no idea of just what to omit from his diet. The booklet gave the daily requisite of a pint of milk, dark cereal, dark bread, one citrus fruit. . . . With the caloric values explained, he saw the need of omitting rich desserts. . . . Mr. N. took the booklet home and from it became more interested in foods. A few weeks later he returned to clinic having lost weight, thereby improving his general treatment."

"I used several of the booklets concerning the care of the teeth in the Children's Clinic whenever I saw children with teeth that were in poor condition."

"This morning in Children's Clinic we had occasion to use a pamphlet on methods for regulation of bowel movements without laxatives. People understand much more quickly if they can see lists of foods in front of them and printed authoritative material is available for them to glance at as you talk to them. They can take this home for study until the material becomes common knowledge."

"Mr. D. was an Italian patient on the urologic ward. Although at discharge he did not have a special diet ordered, I gave him an attractive booklet with a colorful picture of many fruits on it. As he could read only a little, I explained to him about the use of fruits and discussed helpful diet habits with him. I could have told him these facts but he would not have remembered them, I'm sure, if he had not been given the booklet. He seemed very glad to receive it and was not at all offended at my thinking he probably ate too many starches. He was anxious to build up his health and began to realize that this was one important way."

"A mother exclaimed to me that she disliked to have her children ill for she did not know how to care for them adequately or to amuse them. This seemed an excellent opportunity to run over the pamphlets, 'Care of the Sick in the Home' and 'Occupational Therapy,' put out by ——. She was very interested and grateful for them. When I saw her again about a week later, she said that they had been very helpful and had been borrowed by her friends. I gave her two more."

"One of my clinic patients was very much interested in cancer. Her mother had died of cancer of the breast with metastases. I thought she was a little worried about herself. She seemed to be an intelligent person and eager to learn about the early symptoms. I gave her a leaflet on cancer and while waiting for the doctor, went over it with her, emphasizing the necessity of seeing a doctor if any symptoms appeared. It was quite easy reading and she was very pleased with it."

Bibliography. A bibliography of suggested references for the clinical specialty is a necessity for the head nurse and supervisor. The 3 x 5 inch card is the usual size. These are kept in an index box and are available for reference and use by the students. The doctor, head nurse, student, or staff nurse may suggest good references. The head nurses and the supervisors should have access to each others' file boxes.

At the first of each month, the supervisor, in conference with the head nurses, may suggest good articles in the *American Journal of Nursing*, *Public Health Nursing*, *Hygeia*, and the *American Journal of Public Health* which they will want to index. Weekly, she calls attention to articles in the particular clinical field occurring in the *Journal of the American Medical Association*. She directs newly appointed head nurses to the *Index Medicus*, if it is available. The success of the head nurse's bibliography rests usually with the supervisor. She may constantly suggest newer clinical material and hence stimulate her to keep up-to-date.

The head nurse may use the reference cards in several ways. She suggests further references to the student who is preparing a morning conference or clinic, or who is writing a nursing-care study, and, what is fundamentally more important, she sustains her own source of information in the particular clinical field.

Teaching Cards. Ruled cards of 5 x 8 inches in size are useful in preparing and keeping together clinical teaching material. During the last two years, in one institution, it has been possible to

provide the head nurses and supervisors with a supply of these cards, index cards, and filing boxes. There are several advantages to the card system as a teaching aid. First and foremost, each group conference, clinic, or demonstration which the head nurse or supervisor presents has required individual preparation. Every presentation of a colostomy enema requires some revision or change, for patients differ and nursing is adapted to individual patient needs. Hence a card may be inserted, one omitted, or information bracketed for omission. Cards are easily handled during a demonstration. A medical head nurse has ten cards under "Asthma—nursing care" which relate to the special points in care of several different patients presented at group teaching. Certainly this head nurse is building some medical nursing content relative to the condition, asthma.

Contrast this to a head nurse, generally considered good, who for eight years had taught students, and managed her ward without a single teaching note. Each time she had conducted a group conference or clinic, she made a few notes which within the hour were placed in the wastebasket. The reason for discarding her outlines was simply that each teaching period seemed to be different. This demonstrates a real need for teaching supervision. With very little direction, this head nurse during the past year has built up a wealth of clinical source materials.

Many head nurses need direction as to what to include in their teaching material. It should be as useful as possible and relate closely if not directly to nursing care.

Suggested Reference Books for Ward Libraries

1. Books useful in all clinical services:

- American Medical Association: *The Vitamins*, Chicago, Amer. Med. Assoc., 1940, \$1.50.
- Blumgarten, Aaron S.: *Textbook of Materia Medica and Therapeutics*, 7th ed., New York, Macmillan, 1937, \$3.00.
- Broadhurst, Jean, and Leila I. Given: *Microbiology Applied to Nursing*, 4th ed., Philadelphia, Lippincott, 1939, \$3.00.
- Cabot, Richard C., and F. Dennette Adams: *Physical Diagnosis*, 12th ed., Baltimore, Williams and Wilkins, 1938, \$5.00.
- Cooper, Lenna F., Edith M. Barber, and Helen S. Mitchell: *Nutrition in Health and Disease*. 8th ed., revised, Philadelphia, Lippincott, 1941, \$3.00.
- Faddis, M. O., and Joseph M. Hayman: *Textbook of Pharmacology for Nurses*, Philadelphia, Lippincott, 1940, \$3.00.
- Fairchild, Henry P.: *Immigrant Backgrounds*, New York, Wiley, 1927, \$2.75.
- Greisheimer, Esther M.: *Physiology and Anatomy*, 4th ed., Philadelphia, Lippincott, 1940, \$3.50.
- Harmer, Bertha, and Virginia Henderson: *Textbook of the Principles and Practice of Nursing*, 4th ed., New York, Macmillan, 1939, \$3.00.

- Kimber, Diana C., Carolyn E. Gray, and Caroline E. Stackpole: *Textbook of Anatomy and Physiology*, 10th ed., New York, Macmillan, 1938, \$3.00.
- Smith, Martha Ruth: *Principles of Nursing Care*, 2nd ed., Philadelphia, Lippincott, 1939, \$3.00.
- Solomon, Charles: *Pharmacology, Materia Medica and Therapeutics*, 4th ed., revised, Philadelphia, Lippincott, 1940, \$3.00.
- Todd, James C. and Sanford, A. H.: *Clinical Diagnosis by Laboratory Methods*, 8th ed., Philadelphia, Saunders, 1935, \$6.00.

2. *Medical service:*

- Barborka, Clifford J.: *Treatment by Diet*, 4th ed., Philadelphia, Lippincott, 1939, \$5.00.
- Bastedo, Walter A.: *Materia Medica, Pharmacology, Therapeutics and Prescription Writing*, 4th ed., Philadelphia, Saunders, 1938, \$6.50.
- Cecil, Russell L.: *Textbook of Medicine*, 5th ed., Philadelphia, Saunders, 1940, \$9.00.
- Emerson, Charles P., and Jane E. Taylor: *Essentials of Medicine*, 14th ed., Philadelphia, Lippincott, 1940, \$3.00.
- Joslin, Elliott P.: *Diabetic Manual for the Mutual Use of Doctor and Patient*, 7th ed., Philadelphia, Lea and Febiger, 1941 (in revision).
- Means, James H.: *Thyroid and Its Diseases*, Philadelphia, Lippincott, 1937, \$6.00.
- Musser, John H.: *Internal Medicine*, 3rd ed., Philadelphia, Lea and Febiger, 1938, \$10.00.
- Rosenau, Milton J.: *Preventive Medicine and Hygiene*, 6th ed., New York, Appleton-Century, 1935, \$10.00.
- Stevens, Arthur A., and F. A. Ambler: *Medical Diseases for Nurses*, 4th ed., Philadelphia, Saunders, 1940, \$2.75.

3. *Dermatologic service:*

- Nelson, Nels A., and Gladys L. Crain: *Syphilis, Gonorrhea, and the Public Health*, New York, Macmillan, 1938, \$3.00.
- Parran, Thomas: *Shadow on the Land: Syphilis*, New York, Regnal, 1937, \$2.50.
- Stokes, John H.: *Dermatology and Syphilology for Nurses*, 3rd ed., Philadelphia, Saunders, 1940, \$2.75.
- Swartz, Jacob H., and M. G. Reilly: *Diagnosis and Treatment of Skin Diseases*, New York, Macmillan, 1935, \$3.75.
- Tobias, Norman: *Essentials of Dermatology*, Philadelphia, Lippincott, 1941, \$4.75.

4. *Communicable disease service:*

- Bower, Albert G., and E. B. Pilant: *Communicable Diseases for Nurses*, 4th ed., Philadelphia, Saunders, 1939, \$3.00.
- Gage, Nina D., and John F. Landon: *Communicable Diseases*, Philadelphia, Davis, 1939, \$3.50.
- Hasenjaeger, Ella: *Asepsis in Communicable-Disease Nursing*, Philadelphia, Lippincott, 1940, \$1.50.
- Pillsbury, M. E.: *Nursing Care of Communicable Diseases*, 5th ed., Philadelphia, Lippincott, \$3.00.
- Rosenau, Milton J.: *Preventive Medicine and Hygiene*, 6th ed., New York, Appleton-Century, 1935, \$10.00.
- Zinsser, Hans, J. F. Enders, and L. D. Fethergill: *Immunity: Principles and Application in Medicine and Public Health*, 5th ed., New York, Macmillan, 1939, \$6.50.

5. Neurologic and psychiatric service:

- Buckley, Albert C.: *Nursing Mental and Nervous Diseases*, 5th ed., Philadelphia, Lippincott, 1938, \$3.00.
Henderson, David K., and R. D. Gillespie: *Textbook of Psychiatry*, 4th ed., New York, Oxford, 1936, \$6.00.
Hutchings, Richard Henry: *Psychiatric Word Book*, Utica, N. Y., State Hospitals Press, 1939, \$2.00.
Ingram, Madelene E.: *Psychiatric Nursing*, Philadelphia, Saunders, 1940, \$5.50.
Monrad-Krohn, G. H.: *Clinical Examination of the Nervous System*, 7th ed., New York, Hoeber, 1939, \$3.00.
Ross, T. A.: *The Common Neuroses*, Baltimore, Williams and Wilkins, 1937, \$4.00.

6. Pediatric service:

- Aldrich, C. A., and M. M. Aldrich: *Babies Are Human Beings*, New York, Macmillan, 1939, \$1.75.
Bancroft, M. C., Elizabeth Pierce, and Bessie I. Cutler: *Pediatric Nursing*, 3rd ed., revised, New York, Macmillan, 1938, \$3.00.
Boynton, P. L.: *Psychology of Child Development*, Philadelphia, Educational Publishers, 1938, \$2.75.
Faegre, Marion L., and John E. Anderson: *Child Care and Training*, 5th ed., revised, Minneapolis, University of Minnesota Press, 1940, \$2.50.
Gessell, Arnold, and Frances Ilg: *Feeding Behavior of Infants*, Philadelphia, Lippincott, 1937, \$5.00.
Holt, L. Emmett, and Rustin McIntosh: *Diseases of Infancy and Childhood*, 11th ed., New York, Appleton-Century, 1939, \$10.00.
Jeans, Philip C., and Winifred Rand: *Essentials of Pediatrics for Nurses*, 3rd ed., Philadelphia, Lippincott, 1939, \$3.00.
Meek, Lois Hayden: *Your Child's Development and Guidance Told in Pictures*, Philadelphia, Lippincott, 1940, \$2.00.
Sellew, Gladys: *The Child in Nursing*, 4th ed., Philadelphia, Saunders, 1940, \$2.50.
Strauss, Alma F.: *Keep Busy*, New York, Putnam, 1937, \$1.25.
Thom, Douglas A.: *Everyday Problems of the Everyday Child*, New York, Appleton-Century, 1927, \$2.50.
Zabriskie, Louise: *Mother and Baby Care in Pictures*, 2nd ed., Philadelphia, Lippincott, 1941, \$1.50.

7. Obstetric service:

- Corbin, Hazel: *Getting Ready to be a Father*, New York, Macmillan, 1939, \$1.25.
DeLee, Joseph B., and Mabel C. Carmon: *Obstetrics for Nurses*, 11th ed., Philadelphia, Saunders, 1940, \$3.50.
Hess, Julius H., and Evelyn C. Lundeen: *The Premature Infant, Its Medical and Nursing Care*, Philadelphia, Lippincott, 1941, \$3.50.
Maternity Center Assoc., New York: *Maternity Handbook for Pregnant Mothers and Expectant Fathers*, New York, Putnam, 1932, \$1.00.
Zabriskie, Louise: *Nurses Handbook of Obstetrics*, 6th ed., Philadelphia, Lippincott, 1940, \$3.00.
Zabriskie, Louise: *Mother and Baby Care in Pictures*, 2nd ed., Philadelphia, Lippincott, 1941, \$1.50.

8. Surgical service:

- Cutler, Elliott C., and Robert Zollinger: *Atlas of Surgical Operations*, New York, Macmillan, 1939, \$8.00.

- Dodson, Austin I.: *Synopsis of Genito-Urinary Diseases*, 2nd ed., St. Louis, Mosby, 1937, \$3.00.
- Dwyer, Sheila M., and George W. Fish: *Modern Urology*, Philadelphia, Lea and Febiger, 1940, \$3.25.
- Eliason, E. L., L. K. Ferguson, and E. M. Farrand: *Surgical Nursing*, 6th ed., Philadelphia, Lippincott, 1940, \$3.00.
- Felter, Robert K., and Frances West: *Surgical Nursing*, Philadelphia, Davis, 1937, \$3.50.
- Gellhorn, George: *Gynecology for Nurses*, 2nd ed., Philadelphia, Saunders, 1933, \$2.00.
- Hinman, Frank: *Principles and Practice of Urology*, Philadelphia, Saunders, 1935, \$10.00.
- Homans, John: *Textbook of Surgery*, 4th ed., Baltimore and Springfield, Ill., Thomas, 1936, \$8.00.
- Lowsley, Oswald S., and Kirwin, T. J.: *Urology for Nurses*, Philadelphia, Lippincott, 1936, \$2.40.
- Mason, Robert L.: *Preoperative and Postoperative Treatment*, Philadelphia, Saunders, 1937, \$6.00.

9. *Orthopedic service:*

- McBride, Earl D., and Winifred R. Sink: *Crippled Children*, 2nd ed., St. Louis, Mosby, 1937, \$3.50.
- Scudder, Charles L.: *The Treatment of Fractures*, 11th ed., Philadelphia, Saunders, 1938, \$12.00.
- Sever, James W.: *Principles of Orthopedic Surgery for Nurses*, 3rd ed., New York, Macmillan, 1940, \$3.25.
- Shands, Alfred R.: *Handbook of Orthopedic Surgery*, St. Louis, Mosby, 1937, \$5.00.
- Stevenson, Jessie L.: *Care of Poliomyelitis*, New York, Macmillan, 1940, \$2.50.
- Wilson, Philip: *Experience in the Management of Fractures and Dislocations*, Philadelphia, Lippincott, 1938, \$15.00.

10. *Emergency ward service:*

- American Red Cross: *First Aid Textbook*, revised edition, Philadelphia, Blakiston, 1937, \$60.
- Eliason, Eldridge L.: *First Aid in Emergencies*, 10th ed., Philadelphia, Lippincott, 1941.
- Falk, Henry C.: *Operating Room Procedure for Nurses and Internes*, New York, Putnam, 1934, \$3.00.
- Homans, John: *Textbook of Surgery*, 4th ed., Baltimore and Springfield, Ill., Thomas, 1936, \$8.00.

A Suggested List of Organizations from Which Pamphlets and Reprints May Be Secured at Little or No Cost

Write to each organization for list of publications.

- American Dental Association, Bureau of Public Relations, 212 East Superior St., Chicago.
- American Dietetics Association, 185 North Wabash Ave., Chicago.
- American Federation of Organizations for the Hard of Hearing, 1537 Thirty-fifth St., N.W., Washington, D. C.
- American Heart Association, 1790 Broadway, New York.
- American Medical Association, 535 West Dearborn St., Chicago.
- American Nurses' Association, 1790 Broadway, New York.
- American Public Health Association, 1790 Broadway, New York.

- American Social Hygiene Association, 1790 Broadway, New York.
 American Society for the Control of Cancer, 1250 Sixth Ave., New York.
 Child Study Association, 221 West Fifty-seventh St., New York.
 Community Service Society of New York, 105 East Twenty-second St., New York.
 Family Welfare Association of America, 122 East Twenty-second St., New York.
 John Hancock Life Insurance Co., Boston.
 Maternity Center Association of New York, 1 East Fifty-seventh St., New York.
 Metropolitan Life Insurance Co., Welfare Division, 1 Madison Ave., New York.
 Milbank Memorial Fund, 40 Wall St., New York.
 National Committee for Mental Hygiene, 1790 Broadway, New York.
 National Health Council, 1790 Broadway, New York.
 National League of Nursing Education, 1790 Broadway, New York.
 National Organization for Public Health Nursing, 1790 Broadway, New York.
 National Recreation Association, 315 Fourth Ave., New York.
 National Society for the Prevention of Blindness, 1790 Broadway, New York.
 National Tuberculosis Association, 1790 Broadway, New York. Apply to State and Local Tuberculosis Associations.
 New York Diabetic Association, 22 East Fortieth St., New York.
 Prudential Life Insurance Co. of America, Newark, New Jersey.
 State and Local Departments of Health.
 U. S. Children's Bureau, Department of Labor, Washington, D. C.
 U. S. Office of Education, Department of the Interior, Washington, D. C.
 U. S. Public Health Service, Washington, D. C.

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 * Bailey, D. Maxine: How to Mount and File Pamphlets, *Amer. Jour. Nursing*, **39**:1113-1116, 1939.
 Bossing, N. L.: *Progressive Methods of Teaching in Secondary Schools*, Boston, Houghton Mifflin, 1935, Chap. 12.
 * Committee on Curriculum of the National League of Nursing Education: A List of Books Suggested for Nursing Libraries, New York, National League of Nursing Education, 1790 Broadway, 1941.
 Committee on Curriculum of the National League of Nursing Education: Illustrative Materials for Use in Nursing Schools, (in revision), New York, National League of Nursing Education, 1790 Broadway, 1937.
 Ewing, Nan H.: Educational Possibilities in Clinical Charts, *Amer. Jour. Nursing*, **31**:1279-1282, 1931.
 Harker, Goldie D.: Developing Our Nursing School Library, *Amer. Jour. Nursing*, **39**:853-856, 1939.
 Leitzke, Ella: Procedure Books That Stay Put, *Amer. Jour. Nursing*, **40**:1012, 1940.
 * National League of Nursing Education: A Library Handbook for Nursing Schools, New York, National League of Nursing Education, 1790 Broadway, 1936.
 * Nelson, Alice Berry: Pamphlets and Clippings, *Amer. Jour. Nursing*, **41**:45-47, 1941.

- Sink, Winifred R.: Make Your Own Slides, Amer. Jour. Nursing, **39**:508, 1939.
- Suggestions for Libraries, Amer. Jour. Nursing, **40**:146-149, 1940.
- Ward Library Books, Amer. Jour. Nursing, **38**:1099-1100, 1938.
- How to Use the Index, Amer. Jour. Nursing, **41**:183-184, 1941.
- * Wayland, Mary M.: The Hospital Head Nurse, New York, Macmillan, 1938, Chap. 19.
- Wigmore, Ethel: On Making and Using a Bibliography, Amer. Jour. Nursing, **36**:463-468, 1936.

Evaluation

PURPOSE AND USE OF EVALUATION METHODS

THE PURPOSE of evaluating the ward-teaching program is to determine, as nearly as possible, its worth and effectiveness in terms of its stated objectives. Although stated objectives may not be completely attained, periodic evaluations should show some progress toward their fulfillment. Attention to evaluation technics usually implies intention in progressive improvement of the program.

After a program has been under way for a year or longer, various evaluation methods should be considered. At first, in an effort to set up a plan, the emphasis will have been entirely on the induction process, on methods of teaching, and on required time periods. As soon as the program has good footing, it should be scrutinized. Its early development is slow, hence a critical evaluation should not lead to discouragement, but to insight into advances, however small.

Evaluation is useful in determining the rate of progress of the program, that is, how much progress is possible as an average in the course of a year, in determining the variable abilities and interests of the head nurses in informal teaching, and in effecting guidance in promotions in the head nurse group. Evaluation and testing are useful in defining the ability of the student in giving planned, individualized nursing care which extends effectively into the community. Such definition of ability is invaluable in the further direction and guidance of the student. The statement has been made that the ward-teaching program should improve directly the nursing care which the individual patient receives. Quality nursing should increase with an effective ward-teaching program. At present no exact methods exist for evaluating this improvement; however, we measure it indirectly by several of the technics suggested in this chapter.

KINDS OF EVALUATION

There are two kinds of evaluation which are adaptable to a ward-teaching program. The first is a *general evaluation* of the program as a whole, while the second is an *evaluation of student-nurse achievement*.

General Evaluation. A general evaluation of the ward teaching is an evaluation of the more formal program or of the group teaching. It is in terms (a) of the *time* or amount of teaching, (b) of the *content*, (c) of the *method in relation to content*, and (d) of the *range of methods used*.

The *time* given to group ward teaching varies from ward to ward, and from week to week. It varies also with the needs of the nurses on the ward. Because of the frequency of holidays and what seem at present to be unavoidable omissions, a monthly or four-weekly average of teaching hours per ward gives a fairer basis for comparison than does a weekly average. Since the ward teaching should relate to the patient's needs, teaching time is calculated exclusive of fire drills, uniform inspection, and review of administrative routines. The time given to individual teaching is usually not included in calculating the total average hours per ward per week. The obvious reason is that it is very time-consuming. The head nurse and supervisor are expected to suggest, to assist, and to show the student better nursing care. It would be difficult to tabulate completely this informal, individual teaching for each student. Certainly in a beginning program, this amount of time required for recording and checking individual teaching can be spent to better advantage.

A time goal should be set. Although 150 minutes per week is desirable, the standard for the beginning program may be much lower. Quantity is one measuring rod and a useful one. However, it must be considered in relation to content and method.

The *content* for group teaching for each service is determined by the supervisor and head nurse. It is an evolving content as ward procedures and experiences change. The criteria for the selection of content, see page 94, are useful in evaluating the content actually included. The records of students in a clinical service in any one year should show similarity in subject matter. Too frequent repetition of topics should be avoided.

The *method in relation to content* is significant in evaluating the program. It is important to know the best method of presenting the particular teaching at hand. Does the method selected represent a wise choice? Is the method well used?

MASSACHUSETTS GENERAL HOSPITAL
SCHOOL OF NURSING

OBSERVATION RECORD—PLANNED WARD INSTRUCTION

Ward.....Date.....Time.....Number Present.....
Teaching Activity.....Instructor.....Observer.....
Topic.....On Master List.....

I. *Subject Matter*

Knowledge of: Accurate and up-to-date
Comprehensive
Selection of: Pertinence
Importance
Method: Lecture, Demonstration
Discussion
Use of illustrative material, Blackboard illustrations
Questions: Number asked Quality
Include few examples

II. *Instructor's Presentation*

Conventional, Informative, Concise, Clear, Audible
Inspirational, Vital, Resourceful, Original
Lacking in Organization, Lacking in Spontaneity

III. *Student Response*

Knowledge of patient's history or of specific assignment
Questions asked
Interest and attention of all present
Contributions made

IV. *Class Management*

How did physical situation help or hinder?
Lighting Noise Ventilation Seating capacity

V. Purpose of this teaching: Was it accomplished?

VI. Should this teaching improve the nursing care of one patient?

Was interest shown in the patient's nursing needs?
How did the (instructor) do this?

VII. Recommendations made:

FIG. 28. Form for Observation Report—Planned Ward Instruction.

OBSERVATION RECORD—MORNING REPORT

I. Was the Night Nurse's knowledge of patients comprehensive or superficial?

III. Night Nurse's Presentation

IV. Head Nurse and Student Response

V. Class Management

VI. Was the purpose of the Report accomplished?

VII. Recommendations made:

FIG. 29. Form for Observation Record—Morning Report.

The *range of methods* used is also important. Is interest maintained by variation in method? Is a wide range of method emphasized? Does the range show emphasis on the more important ward-teaching technics?

OBSERVATION RECORD FOR EVALUATION

An observation record for the evaluation of planned ward instruction and for the morning report may prove useful in appraising the head nurse's ability in informal teaching. Such a record has a definite value but its introduction and use need to be carefully planned. Before the supervisor begins to evaluate the head nurse's teaching, she must know whether or not the head nurse has had instruction in teaching methods. This may be obtained in an academic institution or as part of an in-service staff program.

Certainly the degree of development of the head nurse's ability as a teacher is one criteria for evaluating the success of the ward-teaching program. The head nurse must understand the purpose of the observation record and its future use. The comments from each observation period should be discussed with the head nurse before the record is filed. Unless student nurses are given formal instruction in principles and methods of teaching, the record should not be used in judging their teaching. An observation record is shown on page 267. Teachers' colleges have available many kinds of observation records for evaluating practice teaching, which are suggestive.

TYPICAL PROCEDURE FOR OBSERVATION

The following suggestions may prove helpful to the beginning supervisor who is visiting and observing ward instruction.

1. When observing individually, enter the room quietly and remain inconspicuous.
2. Be familiar with the observation report before making any observations.
3. It will be found helpful to read the chapter describing the method being observed and one of the comprehensive references completely, before observing the teaching period. This will enrich your knowledge of what to observe.
4. When reading a general reference for this purpose, first read rapidly to get the general outline of the contents. Then reread

carefully the parts which seem to have an important bearing on what you are to observe.

5. Take notes carefully during the observation. A complete record will help you in making a final summary and recommendations.

6. If a discussion is to follow, organize your notes with the highlights itemized.

EVALUATION OF STUDENT ACHIEVEMENT

Although ward teaching centers about the patient, one of its major objectives is to teach the nurse how to administer professional nursing care. Many changes need to be effected in the student to promote the desired growth. Several ways of determining the student's strengths and weaknesses are listed:

1. Anecdotal record.
2. Efficiency record-rating scale.
3. Check sheets for procedures and for situations.
4. Comprehensive examinations.
5. Individual conference and interview.
6. Checking on patients' hospital and discharge instructions.
7. Patients' commendations and complaints.

1. The *anecdotal record* is the record of a series of typical nursing situations of one student. An anecdote is defined by Webster as "a narrative, usually brief, of a separable incident or event of curious interest, often biographical." It is the head nurse's or supervisor's description of the way in which the student planned and gave care to one or more patients, recognized and dealt with nursing problems, and considered the future needs of the patient. Anecdotes may be kept on small cards or in narrative form. They afford specific points for the individual conference. They may give specific examples of co-operation, rapidity of work, ingenuity, skill, and adjustment. They form the basis for the efficiency or ward report. In several schools, with good ward-teaching programs, the anecdotes are appended to the efficiency report; in others, summarized by the supervisor and the summary placed in the permanent folder of the student. Typical anecdotes may be used to illustrate characteristics on the ward report.

2. The *efficiency record* or rating scale is used to determine the qualities and progress of the nurse in a given clinical situation. If well used, it is a tool in further guidance. The period of observa-

tion included in the report should be somewhat standardized. Generally it should be not less than four weeks because of the adjustments which a nurse may need to make when beginning work on an unfamiliar clinical service, and not longer than three months due to the multiplicity of situations covered.

The head nurses, through an in-service program, may be instructed in the correct and increasingly better use of this rating scale. An interpretation of terms or phrases, the typical profile graph for the average student, the fair use of anecdotes as examples, the specificity of remarks, and the value of student conferences regarding the determined rating may be presented to advantage.

A *ward report* is included on pages 271-272. The two sections which refer specifically to planned ward instruction are starred. Several methods of use are suggested.

After the student has been in the ward for a period of two weeks, the head nurse may mark the ward report in pencil. The head nurse and student discuss the report with its indications of strengths and weaknesses. The student is given an opportunity for improvement. During the last week in the ward the rating is completed. Since effecting growth is a major purpose of the report, the original pencil marks may be erased or a dotted line may be drawn across a characteristic to show the degree of improvement effected in a limited time period.

3. A *check sheet* for advanced clinical procedures and situations may be helpful as a tool in evaluation. This list for advanced procedures might be similar to the one used for the basic procedures. Check lists for nursing situations involving major disease conditions could be used for evaluating the ability of the student in caring for a rather typical patient with, for example, pneumonia, arthritis, or heart disease. If such a check list were used, adequate time would need to be provided for a fair observation period and the situation selected should be a typical one.

4. The *comprehensive examination* on the clinical content obtained through the ward-teaching program is a splendid evaluation tool. It can measure the amount of medical and nursing information which the student has received, the application of scientific principles to actual ward situations, and the individual thinking of the student. It is preceded, of course, by a pre-test which has been given to test beginning information. Although it may be given during the first few days of the new clinical service, it is preferable to give it seven to ten days before the new experience is undertaken;

this allows time for evaluation and guidance through conference, and provides a method of avoiding incorrect applications of scientific information. Obviously this method could not be followed unless the supervisor was aware of the schedule changes at least ten days before the pre-test was to be given.

There should be a definite correlation between the pre-test and comprehensive test. The relation can best be attained through careful planning and continuity in the ward-teaching program. The pre-test should be indicative of the academic background of the student. The head nurse, supervisor, and instructors knowing the results of the pre-test, should organize the ward program to provide for the deficiencies and weaknesses noted, as well as opportunity for growth in the direction of the indicated strong points. Clinics, conferences and assignments would then be related directly to the needs of the students and integrated with the particular service.

The comprehensive examination or end of service test is given during the last week in the clinical service and is followed by a conference. Additional assignments may be made during this last week, as indicated by the test. Although this type of examination is used most effectively when experience in a clinical field is continuous, it may be used in an interrupted medical and surgical service. Each specialty requires a different range of materials in its comprehensive test. However, they should be so constructed that each comprehensive test is applicable in some measure to all services.

One method of compiling tests of this type is to select a typical ward situation. It should be a simple rather than a complex one until a little experience in testing has been obtained. The head nurse is best fitted to make this selection. Copies of this situation should then be given to the instructors in science and nursing arts, the supervisor and the teaching dietitian. This group with the head nurse should decide on the objectives, the types of questions to be used, the facts, nursing technics and attitudes involved and should then formulate questions which deal with their own field of experience. The chairman of a group of this kind should be the person with the most experience in testing as she will need to edit the questions.

The following situation has been selected for both a pre-test and an end-of-service test. A forty-year-old man with a fracture of the neck of the femur was admitted to Ward N. Two days later his hip was nailed and Russell traction was applied. Preoperative medication was nembutal, grains 1 ss. at bedtime and at 7:00 A.M. and

morphine sulfate, grains $\frac{1}{4}$ and scopolamine, grains $\frac{1}{150}$, subcutaneously, at 7:30 A.M. No medical complications arose during his stay in the hospital.

If the purpose of the pre-test is to review background and to ascertain the student's previous experience, the questions should deal with an understanding of such facts and technics as:

1. Anatomic and functional relationships of femur to other bones of skeleton and to soft tissues.
2. Structure of femur.
3. Bone regeneration.
4. Kinds of organisms frequently found on the skin.
5. Value of mechanical cleansing and of soap and water.
6. The disinfectants frequently used on the skin with a consideration of the factors affecting their action.
7. The expected action, average dosage, toxic effects of nembutal, morphia and scopolamine, and nursing care involved in the administration of these drugs.
8. Fractional dosage.
9. An adequate diet for an adult.
10. The foods selected for a house diet, pre-operative breakfast, liquid diet, and soft diet.
11. Fundamentals of good nursing care.
12. Pre-operative preparation.

If, however, the head nurse and supervisor desire to know the extent of the student's knowledge they might well include such items as would usually be placed in an end-of-service test, for example:

1. Type of first aid which could be given this patient.
2. Preparation of the skin for an orthopedic operation.
3. Immediate postoperative care following spinal anesthesia.
4. Understanding of mechanics of Russell traction.
5. Nursing care of the patient in Russell traction.
6. Prevention of complications such as foot drop and respiratory infections.
7. Importance of occupational and diversional therapy.
8. Importance of exercise and physical therapy.
9. Teaching patient crutch walking.
10. Preparing the patient for return to the community.

All the questions dealing with the listed topics would constitute a comprehensive examination in one situation.

The period between the pre-test and end-of-service test includes several series of teaching units, each perhaps having its own quiz based on the principles used in the pre-test but pertinent to the actual patients on the ward. As in the case of all tests each should be followed by conference.

If the major disease covered by a series of ward-teaching periods represents one specialized service as tuberculosis, it is quite probable that this quiz will be the comprehensive test for that service. Generally this would not be the case, as for instance, a medical service program would include a series of units on pneumonia, cardiac disease, diabetes, and other common conditions each with its own quiz. The comprehensive examination would then include such parts of each as seemed most pertinent and the continuity would be unbroken.

5. By the *individual conference and interview*, the head nurse and supervisor are able to determine the sensitivity of the student to patients' needs and problems and to nursing situations. Has the student developed insight into the significant social problems and seen the relationship between them and the convalescent instruction? Is the student able to put herself in the patient's place? Is the student eager to plan carefully for care after discharge? Has she done this? How much individual thinking has she done in regard to the needs of this patient and has it been effective? Has the student shown growth of insight through the individual ward instruction?

The nursing-care plans and studies which a student writes over a period of twelve to eighteen months indicate in part the tenor of the teaching program. Just as a series of nursing-care studies by one student should show definite improvement, so also those of many students in an evolving ward program should portray an ever deeper insight into the patient's needs and into nursing situations.

6. Evaluation of the results of the *discharge instructions* may be done in part through the patient's follow-up visits to the out-patient clinics. The head nurse and student may keep account of the dates for return appointments of certain groups of patients. The ward time-schedule is planned so that the nurse may be in the clinic to talk with the patient and learn of his progress. This is one excellent way of evaluating the effectiveness of the discharge teaching. If the follow-up clinic visit can be arranged for the nurse who has

a special study interest in a particular patient, the planning of the convalescent teaching might become more effective.

If an outline of the facts which students should teach in each common condition or group of conditions, could be set up, an evaluation of the instructions could be made. This appraisal should review what the student told the patient, what she planned to have him do, how many instructions the patient was able to carry out at home, what actually was accomplished and the additional instruction which is necessary.

7. *Patients' comments* are significant if they represent a common or group opinion. The average patient is more than generous in his consideration of the nurse. Their evaluations are helpful in that they show their response to the nurse's effort and hence, to an extent, her effectiveness as a teacher. A complaint may be unbiased or biased, hence a series of unfavorable comments is more significant than isolated complaints.

A further method of evaluation is by an analysis of the ward-teaching records of the student. Is variety in case experience given? Has adequate experience been provided in the major disease conditions? To what extent has the procedure practice with and without supervision been obtained? Has observation or experience been possible for most of the procedures listed? Do the records show that group ward teaching was attended? What is the range and major emphasis in the group conference and clinic topics? According to the records, what are the stresses and weak points in the planned group teaching? How many of the nursing-care studies listed actually represent major disease conditions? Was good variety observed in the selection of patients for detailed study?

It is not new for nurses critically to evaluate methods in teaching the basic sciences and clinical subjects. The same critical evaluation should be given to the ward-teaching program. Suggestions for studying the program have been given. New ideas will evolve as the plan becomes more securely established and as more is learned about the ward-teaching program.

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PART THREE
Supplementary Materials

PART THREE

Supplementary Materials

Section A

Topics for Ward Teaching

THE following lists of topics for ward teaching are typical of those in the "Ward Instruction Record" in use at the Massachusetts General Hospital. A sample page on which topics are listed as in the Record is shown on page 284.

1. Medical Ward Teaching

- | | |
|------------------------------|--------------------------|
| Acute yellow atrophy | Decubitus ulcer |
| Adenoma of thyroid | Dental caries |
| Admission of medical patient | **Diabetes mellitus |
| *Anemia—primary | *Diarrhea |
| *Anemia—secondary | Diathermy |
| **Arteriosclerosis | **Duodenal ulcer |
| **Arthritis | **Dysentery |
| Apparatus | **Dyspnea |
| *Ascites | Electrocardiogram |
| *Asthma | **Edema |
| Basal metabolism | Embolism |
| Bronchiectasis | Fecal impaction |
| *Bronchitis | **Gastric ulcer |
| Carcinoma of the stomach | Gastroscopy |
| Carcinomatosis | Gastro-intestinal charts |
| Cardiospasm | Gonococcic arthritis |
| Cerebral accident | Gout |
| **Cholecystitis | **Heart disease |
| **Cholelithiasis | arteriosclerotic |
| Cirrhosis of liver | bacterial |
| **Common cold | congenital |
| **Constipation | hypertensive |
| *Coronary thrombosis | rheumatic |
| **Colitis | syphilitic |
| **Cyanosis | *Heart pain |
| *Decompensation | *Hay fever |

- | | |
|---|--------------------------|
| Hemophilia | *Pleurisy |
| **Hemorrhage | **Pneumonia |
| Hodgkin's disease | lobar |
| *Hyperthyroidism | broncho |
| Hypothyroidism | Pneumothorax |
| *Indigestion | Poisoning—name kind |
| **Influenza | Proctoscopy |
| *Jaundice | Purpura |
| Leukemia | *Rheumatic fever |
| Lymphadenitis | *Serum sickness |
| Medicines—new—list names | **Shock |
| Myxedema | *Sinusitis |
| **Nephritis | Taenia saginata |
| *Obesity | Thyrotoxicosis |
| *Orthopnea | *Tonsillitis |
| Oxygen mask and nasal oxygen | **Tuberculosis—pulmonary |
| Oxygen tent | *Typhoid fever—screen |
| *Palpitation | Uremia |
| Pancreatitis | Uremic coma |
| Parasitic gastro-intestinal infections—name kinds | *Vincent's angina |
| Peritonsillar abscess | Visceroptosis |
| **Phlebitis | **Vomiting |

Other conditions or aspects of nursing which cannot be classified on the above list.

*Blindness

*Deafness

Administrative routines. List but do not include in total hours of teaching.

- | | |
|------------------------------|-------------------------|
| Introduction to ward | Medical standing orders |
| Fire drill | Planning nursing care |
| Administration of medicines | Hospital hospitality |
| Clinical charts and charting | Noise prevention |
| Housekeeping | |

2. Dermatologic Ward Teaching

- | | |
|-------------------------------------|--------------------------------------|
| *Acne vulgaris | *Epidermophytosis |
| Admission of dermatological patient | *Eczema |
| Alopecia areata | *Erysipelas |
| Angioneurotic edema | Erythema nodosum |
| Application of ointment and pastes | Herpes zoster |
| Arsenical jaundice | *Impetigo contagiosa |
| Baths | Lupus erythematosus |
| oatmeal | Lupus vulgaris |
| salt | Lupus—preparation for curettage |
| starch | Malarial therapy |
| Chancroid | Ointments |
| Compresses | *Pediculosis |
| boric | Pemphigus |
| potassium permanganate | Pityriasis rosea |
| Dermatitis | Preparation for physical examination |
| atopic | Pruritis |
| exfoliative | Psoriasis |
| seborrheic | Scabies |
| | Scleroderma |

Shampoo
 *Syphilis primary—chancre
 Syphilis secondary
 Syphilis tertiary
 Tinea capitis

Ultra violet lamp
 Urticaria
 Warts
 Washes

Other conditions or aspects of nursing which cannot be classified on the above list.

*Blindness
 *Deafness

Mental hygiene

Administrative routines. List but do not include in total hours of teaching.

Introduction to ward

Fire drill

3. Surgical Ward Teaching

**Abortion
 Abscess
 Acidosis
 Adhesions—abdominal
 Admission of surgical patient
 *Amputation
 **Appendicitis
 **Breast malignancy
 radical mastectomy
 **Breast
 benign neoplasm
 mastectomy
 Bronchiectasis—bronchoscopy
 Buerger exercises
 **Burns
 Carcinoma of lung
 Carcinoma of rectum
 colostomy
 combined resection
 Carcinoma of stomach
 **Carcinoma of reproductive system
 Carcinomatosis
 *Carbuncle
 *Cellulitis
 **Cervicitis
 **Cervix—repair of lacerations
 **Cholecystitis
 cholecystectomy
 choledochostomy
 **Cholelithiasis—cholelithotomy
 **Colpocoles
 **Cyanosis
 *Dental caries
 Diabetic ulcer
 **Dysmenorrhea
 **Dyspnea
 **Ectopic gestation
 Embolism
 *Empyema
 *Erysipelas
 **Fibroids—uterus
 *Fistulae

**Fractures
 femur
 humerus
 pelvis
 vertebrae
 Frost bite
 *Gangrene
 Goitre—thyroidectomy
 *Gonococcic salpingitis
 **Hemorrhoids
 **Hernia
 Infections of finger
 *Intestinal obstruction
 *Jaundice
 Lobectomy
 Lung abscess
 Lymphadenitis
 *Mastitis
 *Menorrhagia
 *Metrorrhagia
 Ochsner's regime
 **Osteomyelitis
 Pavaex boot
 **Pelvic floor lacerations
 **Peritonitis
 **Peptic ulcer
 total gastrectomy
 subtotal gastrectomy
 posterior gastro-enterostomy
 **Phlebitis
 Plastic operations
 Pneumonectomy
 Pneumothorax—spontaneous
 Postoperative pneumonia
 **Postoperative shock and hemorrhage
 Pre-operative preparation—physical and mental
 Preparation for physical examination
 Preparation for rectal and pelvic examination

- | | |
|---------------------------------|---------------------------------------|
| *Prolapse of uterus | Thrombo-angiitis obliterans |
| *Pruritus | Tuberculosis of lymph nodes |
| Raynaud's disease—sympathectomy | Tuberculosis of mesentery |
| *Rectal abscess | Tuberculosis of mouth |
| **Retroversion of uterus | Tuberculosis of skin |
| **Septicemia | **Uterine hemorrhage |
| Skin graft | **Varicosities—ligation and injection |
| **Sterility | Varicose ulcers |
| Stricture of esophagus | Visceroptosis |
| Stricture of rectum | **Vomiting |
| Tetanus | Weight control |
| Thoracoplasty | |

Other conditions or aspects of nursing which cannot be classified on the above list.

*Blindness

*Deafness

Administrative routines. List but do not include in total hours of teaching.

- | | |
|------------------------------|--------------------------|
| Introduction to ward | Needles and syringes |
| Fire drill | Planning nursing care |
| Clinical charts and charting | Surgical standing orders |
| Dressing carriage | Hospital hospitality |
| Housekeeping | Noise prevention |

4. Orthopedic Ward Teaching

- | | |
|---------------------------------|--------------------------------------|
| Admission of orthopedic patient | *Kyphosis |
| *Amputations | Lordosis |
| *Ankylosis | Muscle spasm |
| **Arthritis—cup arthroplasty | Neoplasms |
| **Atrophy | benign |
| Balkan frame | malignant |
| Bandaging | **Osteomyelitis |
| bender | Paralysis |
| plaster | **Poliomyelitis—deformities |
| Bicycle | *Posture defects |
| Braces—name kind | Pre-operative preparation |
| Bradford frame | Preparation for physical examination |
| Cast | *Rickets—deformities |
| extremity cast | Roller skating |
| spica cast | Sacro-iliac strain |
| making of | Scoliosis |
| Clubfoot—talipes | Shells—making and covering |
| **Contracture | Slipped femoral epiphysis |
| Crutch walking | Splints—name kind |
| Dislocation of hip | *Sprains |
| Dressings | Strapping |
| Flat feet | Torticollis—wry neck |
| Fracture bed | Traction—preparation for |
| **Fractures of hip | Tuberculosis |
| Fractures of humerus | bones |
| Fractures of spine | joints |
| Fractures of tibia | Walkers—use of |
| Hallux valgus | |

Administrative routines. List but do not include in total hours of teaching.

Introduction to ward

Fire drill

Section B

Ward-Instruction Records

THE following sheet is typical of those set up for each clinical specialty.

METHOD OF RECORDING GROUP WARD INSTRUCTION

The student records the group ward instruction, i.e., conferences, clinics, and demonstrations, which she attends, on the ward-instruction record for the particular clinical service to which she is assigned or, in the instance of a non-segregated service, on the ward-instruction sheet on which the topic is listed.

Each period is recorded opposite the appropriate topic, with a check mark as to the major aspect discussed, i.e., *Disease, Treatment, or Nursing Care*. If a special aspect not included under these headings is discussed, the aspect is noted in the column marked, *Special Aspect*. The teaching is recorded under *Conferences, Clinics, or Demonstrations*, giving the name of the instructor, the date, and time in minutes.

If more teaching is attended than space for recording permits, it may be listed under *Other Conditions or Aspects of Nursing*.

Topic	Special Aspects	Disease	Treatm.	N. Care	Conferences		Clinics		Demonstration		N. C. Plan
					Instructor	Date	Instructor	Date	Instructor	Date	
Adm. of child											
Adm. of infant											
**Anemia - aplastic											
- erythroblastic											
- nutritional											
Anomalies											
**Appendicitis											
*Arthritis											
*Asthma											
*Atelectasis											
Baby bathing											
Baby clothes											
Bassinet making											
**Behavior disorders											
**Birth injuries											
Books for children											
*Burns											
*Celiac disease											
Cellulitis											
Child feeding ;											
instructing parent											
Chorea											
*Cleft lip											
*Cleft palate											
**Colitis											
**Common cold											
**Congenital syphilis											
*Conjunctivitis											
*Convulsive disorders											
Cretinism											
Crib making											
Croup (croup tent)											
Cubicle technic											
					Total		Total		Total		

FIG. 32. Form for Recording Group Ward Instruction—Pediatric Ward.

Section C

Case Experience Records *

PEDIATRIC NURSING

Conditions Which are Basic to the Student's Experience.

[illegible]

FIG. 33. Form for Recording Student's Experience.

*The method of recording case experience is described on page 234.

Section D

Nursing Procedure Records

THE following procedure records are typical of those set up for each clinical specialty.

1. Nursing Procedure Record (A) *Elementary*
2. Nursing Procedure Record (B) *Medical and Surgical Nursing*

METHOD OF RECORDING PROCEDURE PRACTICE

In the columns headed *Demonstration and Supervision*, the head nurse, supervisor, or instructor records her initials, indicating that she has given a demonstration of the procedure and that a satisfactory return demonstration has been observed. In the third column, *Ward Experience*, the student records the satisfactory carrying out of the procedure up to and including five times, as 11111.

When the recording of the procedure practice is so far complete, for example, Arm soak, S. D. C. — D. B. — 11111, the ward supervisor draws a red line through the five marks, signifying that the student has had sufficient practice in the procedure. At this time, the supervisor places the date in the last column, headed *Supervisor's Notes*.

A student should not record her procedure experience until initials have been placed in the first two columns, namely, *Demonstration* and *Supervision*.

NURSING PROCEDURE RECORD (A)

ELEMENTARY

Common Nursing Procedures which the Junior Student is expected to master from January until April first; from June until September first.

PROCEDURES	Ward Supervi-			
	Demonstra-	Super-	Exper-	sor's
	tion	vision	ience	notes
Admission of patient				
Assistance with examinations-	Gynecologic			
	Physical			
	Rectal			
Back care, special				
Bath, cleansing				
Beds- Empty				
Occupied				
Recovery				
Binders- Abdominal straight	Surgical ward			
	Scultetus	assignment only		
	NTs			
Cardinal symptoms-	Pulse and Respiration			
	Temperature, mouth			
	Temperature, rectal			
Care-Evening				
Morning				
Discharge of patient-	Care of unit			
	Procedure of discharge			
Diversional therapy, initiation of				
Enemata, cleansing				
Feeding patient				
Hot water bag, application of				
Ice cap, application of				
Mouth care, special				
Shampoo, cleansing				
Transfer of patient				

Checking Special Duties: Each square represents one week of a special duty. Check by entering in square the ward where experience was obtained.

Special Duties:													
Kitchen													
Linen Closet													
Medicine Closet													
Thermometer Trays													
Utility room													

FIG. 34. Form for Recording Elementary Procedures.

NURSING PROCEDURE RECORD (B)

INCLUDING

MEDICAL AND SURGICAL NURSING

PROCEDURES	Demonstra- tion	Super- vision	Ward Exper- ience	Supervi- sor's notes
Appliances- Heel ring				
Oakum pad				
Sling				
Application and Care of Casts				
Taping of Casts				
Arm soak				
Artificial respirations				
Assistance with Examinations- Eye				
Neurologic				
Assistance with Treatments, including aftercare				
Aspiration of joint				
Biopsy- Cervical glands				
Cervix				
Rectum				
Blood culture				
Gastric analysis				
Gastroscopy				
Gavage				
Hypodermoclysis				
Intravenous infusion- Changing of flask				
Glucose or saline				
Sera				
Lavage				
Lumbar puncture				
Myringotomy				
Paracentesis, abdominal				
Pericardial aspiration				
Pneumothorax				
Proctoscopy				
Skin temperature				
Thoracentesis				
Throat culture				
Transfusion				
Bandaging- Arm				
Eye				
Feet				
Hand				
Head				
Leg				
Mastoid				
Baths- Alcohol sponge				
Contrast				
Sitz				

FIG. 35. First Page of Medical and Surgical Nursing Form.

NURSING PROCEDURE RECORD (3)

PROCEDURES	Demonstra- tion	Super- vision	Ward Exper- ience	Supervi- sor's Notes
Beds- Cradle				
Electric light				
Fowler				
Fracture-Bradford frame				
Traction apparatus				
High headrest				
Shock				
Binders- Alexander				
Breast				
Chest				
Bladder Treatments- Bags, care of, Foley				
Hagner				
Smith-Davis				
Catheterization, Glass catheter				
Rubber catheter				
Closed bladder drainage				
Instillation of inlying catheter				
Foley bag				
Mushroom tip				
Instillation of medication				
Irrigation through glass catheter				
Retention catheter				
Tidal drainage				
"Blow Bottles," use of				
Cardinal symptoms, ascertaining of-				
Apex and radial pulse				
Blood pressure				
Charting- Apex and radial pulse				
Blood pressure				
Chills				
Medications				
Routine (T.P.R., dejecta, operation, transfer, discharge)				
Treatments				
Compresses (fomentations)- Hot, sterile				
Hot, unsterile				
Decubitus ulcers, care of				
Ear Treatments- Drops				
Irrigations				
Enemata- Carminative				
Colostomy				
High cleansing				
Retention				
Enteroclysis (colonic irrigation)				
Eye Treatments- Compresses				
Drops for dilation				
Irrigation				
Ointment				

FIG. 36. Medical and Surgical Nursing Form, Page 2.

NURSING PROCEDURE RECORD (B)

PROCEDURES	Demonstra- tion	Super- vision	Ward Exper- ience	Super- sor Note
Foot Care- Diabetic care				
Mustard foot bath				
Pavane boot				
Special foot care				
Gastric and Jejunostomy Treatments				
Feeding- Gastrostomy tube				
Jejunostomy tube				
Levine tube				
Miller-Abbott tube				
Gastric I diet				
Gastric II diet				
Typhoid diet				
Ice collar				
Inhalations- Carbon dioxide				
Medicated steam				
Oxygen mask				
Oxygen nasal tube				
Oxygen tent				
Injections- from Ampoule				
Insulin syringe and dosage				
Intramuscular				
Subcutaneous				
Medications, rectal				
Mustard paste				
Nasal treatments- Atomizer				
Drops				
Irrigation				
Packing				
Packs- Arthritic				
Cold wet				
Hot wet				
Perineal care				
Postural drainage				
Post-mortem care				
Poultices- Hot wet				
Flaxseed				
Precaution technic- Type R (Respiratory)				
Type E (Enteric)				
Type G (Genito-urinary)				
Type W (Infected wound)				
Preparation of patient for and aftercare of:				
Basal metabolism				
Bronchoscopy				
Cystoscopy				
Electrocardiogram				
Fever therapy				
Peritoneoscopy				

FIG. 37. Medical and Surgical Nursing Form, Page 3.

NURSING PROCEDURE RECORD (B)

PROCEDURES	Demonstra- tion	Super- vision	Ward Exper- ience	Supervi- sor's Notes
Tests- <u>Glucose tolerance</u>				
<u>Liver function</u>				
<u>Phenolsulphonephthalein</u>				
<u>Renal function</u>				
<u>Urine concentration</u>				
<u>Urine dilution</u>				
X-Ray- <u>Abdominal flat plate</u>				
<u>Barium enema</u>				
<u>Gastro-intestinal series</u>				
<u>Graham test</u>				
<u>Intravenous pyelogram</u>				
<u>Retrograde pyelogram</u>				
<u>Proctoclysis</u>				
<u>Respirator, care of patient in</u>				
Restraints- <u>Anklets or wristlets</u>				
<u>Bedboards or crib sides</u>				
<u>Fish net</u>				
<u>Sheet</u>				
Shampoo- <u>Carbolic</u>				
<u>Derbac</u>				
Specimens, collection for lab.-				
<u>Feces</u>				
<u>Sputum- Routine</u>				
<u>For typing</u>				
<u>Urine- Fractional</u>				
<u>Single clean</u>				
<u>Sterile</u>				
<u>24 hour</u>				
<u>Vomit</u>				
Stupes- <u>Non-medicated</u>				
<u>Turpentine</u>				
Suction- <u>House</u>				
<u>Wangensteen</u>				
<u>Water seal</u>				
<u>Suppositories, insertion of</u>				
<u>Surgical Nursing</u>				
<u>Care of dressing cart</u>				
Dressings- <u>burns</u>				
<u>Cecostomy or colostomy</u>				
<u>Empyema</u>				
<u>Packing with Dakins or Saline sponges</u>				
<u>Regular dry</u>				
<u>Removal of clips</u>				
<u>Removal of skin sutures</u>				
<u>Skin graft</u>				
<u>Strapping- Butterfly</u>				
<u>P.R.N.</u>				

FIG. 38. Medical and Surgical Nursing Form, Page 4.

NURSING PROCEDURE RECORD (B)

PROCEDURES	Demonstration	Super-vision	Ward Experience	Supervisor's Notes
Dressings- Stump				
Thyroid				
With irrigation-				
Asepto				
Asepto & Catheter				
Preparation for operation -				
Physical and mental				
Skin, double surgical				
Vein, compress swathe				
Teaching patients- Arthritic exercises				
Buerger exercises				
Colostomy instruction				
Care of belt or bag				
Care of skin locally				
Dilation				
Evacuation- Enema				
Regulation by diet				
Use of laxatives				
Personal hygiene				
Constipation prevention				
Crutch walking				
Diabetic instruction				
Administration of insulin				
Care of teeth				
Foot care				
Personal hygiene				
Urinalysis				
Personal hygiene				
Discharge diet				
Throat Treatments- Gargles				
Irrigations				
Sprays				
Swabs				
Tracheotomy tube, care of				
Ultra-violet lamp (under supervision)				
Urinalysis- Acetone				
Diacetic acid				
Sugar				
Vaginal treatments- Irrigations				
Medication				
Smear				

FIG. 39. Medical and Surgical Nursing Form, Page 5.

NURSING PROCEDURE RECORD (B)

Additions to the above list	Demonstra- tion	Super- vision	Ward Experi- ence	Supervi- sor's Notes

Checking Special Duties: Each square represents one week of a special duty. Check by entering in square the ward where experience was obtained.

Special Duties:													
Medicines													
Senior duty													
Surgical carriage													
Trays and treatments													

FIG. 40. Last Page of Medical and Surgical Nursing Form.

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